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A Report of
THE NATIONAL COMMISSION
FOR
HEALTH CERTIFYING AGENCIES

TO ASSURE CONTINUING COMPETENCE

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Editors:
Denis S. Falk, Executive Director
Neil Weisfeld, JD, MSHyg., Assistant Director
Peggy J. McCarberg, Research Associate

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A Report of
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TO ASSURE CONTINUING COMPETENCE

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FOREWORD

We again enjoy the opportunity to express appreciation to the Bureau of Health Professions, Division of Associated Health Professions, for its support of the Commission's efforts as evidenced by this publication. We are hopeful that this report will be useful to health professionals, certifying agencies, researchers, policy-makers on the federal and state levels, and educators. And, as the work of assuring continuing competence evolves, we look forward to continued cooperation between the public and private sectors.

Dennis S. Falk
Executive Director

Neil Weisfeld
Assistant Director

National Commission for Health Certifying Agencies
Washington, D.C.

September 30, 1980

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LIST OF CONTRIBUTORS

Robert Burmeister, Ph.D., Director, Department of Education, Research and Development, American College of Nursing Home Administrators, Bethesda, Maryland

Eugenia S. Carpenter, M.P.P., Assistant Research Scientist, Department of Health Planning and Administration, School of Public Health, University of Michigan, Ann Arbor, Michigan

Ayres D'Costa, Ph.D., Associate Professor, Health Professions Education, Ohio State University, Columbus, Ohio

Robert C. Derbyshire, M.D., Member, New Mexico Board of Medical Examiners, Sante Fe, New Mexico

Geraldine L. Ellis, R.N., M.S., Director, Division of Peer Review, Health Care Financing Administration, Baltimore, Maryland

Edgar C. Fell, National Simulator Program Manager, Federal Aviation Administration, Washington, D.C.

Thomas D. Hatch, Acting Director, Bureau of Health Professions, Health Resources Administration, Public Health Service, U.S. Department of Health and Human Services, Hyattsville, Maryland

Nathan Hershey, LL.B., Professor of Health Law, Graduate School of Public Health, University of Pittsburgh, Pittsburgh, Pennsylvania

Samuel H. Kalman, Director of Education, American Pharmaceutical Association, Washington, D.C.

Morris Lasky, Director, Health Care Apprenticeship and Training Program, Services Employees International Union, New York, New York

Glen R. Leymaster, M.D., M.P.H., Executive Director, American Board of Medical Specialties, Evanston, Illinois

Diana Mass, Chairperson, Competence Assurance Council, American Society for Medical Technology, Bellaire, Texas

G. Bruce McFadden, M.H.A., Director, University of Maryland Hospital, and Member, Council on Human Resources, American Hospital Association, Baltimore, Maryland

Raymond D. Salman, Ed.D., Director of Professional Licensing, New York State Education Department, Albany, New York

Daniel R. Thomas, Assistant Director, Consumer and Professional Relations Division, Health Insurance Association of America, Chicago, Illinois

PREFACE

A subject almost certain to receive increasing attention as the 1980s progress is the continuing competence of members of the health and health-related professions. Creating mechanisms to assure continuing competence is a challenge facing not only members of the professions but also regulatory bodies and consumers. The subject was deemed of sufficient importance that it was chosen as the theme of the 1979 Educational Conference of the National Commission for Health Certifying Agencies, a voluntary organization involved in setting standards for and promoting the use of certification based on competence. This report includes the proceedings of the conference and also presents a range of opinion and information concerning the assurance of continuing competence.

Assuring continuing competence is not the same as evaluating it. Assurance requires the establishment of a mechanism to control designations of competence in a particular practice domain. Evaluation of competence involves measurement and some form of examination. Continuing education, far and away the most popular tool for assuring continuing competence, typically is not based on individual evaluation.

It is a premise of the Commission, chartered in 1977 as the result of several years of cooperation among voluntary credentialing authorities and government, that the private sector must be heavily involved in occupational regulation. If the federal government acts alone to set standards for reimbursing and recognizing the health professions, the resulting regulatory system is likely to be unrealistic, inefficient, unreceptive to innovation, and intrusive on the constitutional prerogatives of states to regulate health and safety within their borders. But, if the matter is left solely to states, interstate differences will impede mobility and generate confusion, fiscal problems will inhibit the growth and possibly the continuity of credentialing efforts, interprofessional disputes will surface repeatedly in the political and regulatory arenas, and appropriate economies of scale will not be achieved due to the lack of a national program authority. Moreover, regulation of any sort is not likely to work unless it has the active cooperation of the regulated group.

It is possible for the professional associations and certifying agencies in the private sector to use their position to stave off the establishment of continuing competence assurance mechanisms. In the Commission's view, this would be counter-productive and not responsible. The accelerated pace of technologic change in health care in recent years has been too pronounced to render tenable the former proposition that determination of competence at the time of entry into a profession is sufficient to assure competence at later stages in one's career. Growth in health care expenditures combines with overall pressures on the economy to create a public financial need for high quality services delivered at contained costs. Legal pressures in equal employment opportunity and antitrust law are forcing the private sector to gear all standards relating to employment and career mobility to only valid mechanisms, of which a standard of competence based on outdated achievement is a counter-example. Furthermore, it is the responsibility of the private sector to act to promote both continuing and entry-level competence in the interest of improvements in the health care system.

On December 6, 1979, the Commission's Third Annual Educational Conference was held in New Orleans. The conference was predicated on a recognition that no single approach to continuing competence assurance has been designated to be clearly superior to the others in terms of benefits, whether or not those benefits are tied to costs. Several techniques have emerged, however, with promise. The conference considered the techniques of continuing education, re-administration of the entry-level examination, development of a mid-career examination, proficiency testing, practice audit or peer review, and self-assessment. Perspectives on continuing competence assurance were supplied from employers and labor, federal and state governments, law and psychometrics. Not surprisingly, the conference produced no clear direction, except one--that efforts must continue to develop useful assurance mechanisms on the foundations of achievements to date. It is the purpose of this document to summarize those achievements to guide the necessary, pivotal work of the near future.

* * * * * * *

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INTRODUCTION

Professional competence is a synthesis of skill, knowledge, and performance. The ability to transform learning into effective and appropriate action is evidence of such competence. The ability to continue doing so throughout one's career as a health professional is the focus of this report.

Continuing competence is an issue to be addressed once initial entry-level skill is attained. It is ineffectual to focus on retaining or updating knowledge that was inadequately learned initially. Therefore, this report is premised on the assumption that the health practitioner has the minimal skills required of an entry-level professional.

Evidence of initial skill is no longer a sufficient measure of a health professional's abilities. Health care is not a stagnant concept: it is an ever-evolving process. There is little disagreement that technological and scientific advancements quickly render today's knowledge obsolete. Sophisticated patients are aware of this pace and increasingly demand not only skilled health care delivery but also proof of a practitioner's competence.

The National Commission for Health Certifying Agencies' 1979 annual meeting addressed this issue. The Educational Conference was convened in order to survey the broad range of approaches being taken or considered by leaders in the area of continuing competence. The contributions of these leaders in the form of speeches delivered to the conference are presented in Part One of this report.

Part One

As the keynote speaker, Raymond Salman touched on many of the issues later speakers addressed in depth. His speech, reprinted in Chapter 1, reveals his concern for the disrepute being suffered by credentialed professionals and proposes methods to combat it. Continuing competence is the critical issue as he sees it, but Dr. Salman urges restraint: only those programs which can produce desired results should be implemented. Professionals can work to improve themselves with the aid of inventories developed as standards for self-assessment. As this regulator sees it, a viable means of dealing with increased specialization may be limited licensure. Through these methodologies and appropriate discipline, Dr. Salman believes professionals will regain the full measure of respect they deserve.

State and federal governments have become increasingly aware of the need for a way to ensure continued competence. In Chapter 2, Eugenia Carpenter focuses on one state's approach to this issue. Michigan's new Public Health Code authorizes all health boards to develop competency programs over a six-year period. Through concerted effort, the state hopes to achieve both high-quality and cost-effective health care delivery. Support for the program is being carefully developed with the realization that without the cooperation of professionals any program is doomed. By 1984, Michigan plans to have overcome the technical problems of developing a state-wide system of continuing competence.

Like their state counterparts, authorities at the federal level display a growing recognition that traditional continuing education is not the complete answer to the dilemma professions are facing. Prior to any program development, the knowledge and ability appropriate for each profession must be identified, for the sake of the professional and consumer protection as well. Whatever program is developed, continued competence implies re-evaluation over intervals which may vary among professions. Thomas Hatch presents these and other concerns at the national level in Chapter 3.

Re-evaluation and recertification is a concern that the American Board of Medical Specialities has advanced. The Board has developed a Guideline to Recertification which is excerpted in the remarkes of Glen Leymaster in Chapter 4. Ongoing education for physicians is stressed, yet varied approaches are encouraged. The program which is ultimately chosen for physician participation must be susceptible to

The health care field is not alone in its concern with continued competence; the legal profession shares an interest. A credential representing one's achievement is not viewed lightly by the courts. Depriving a practitioner of it can have serious legal consequences. One's possessory interest in a credential as well as one's performance on the job are factors a court may consider if faced with a challenge to a continued competence requirement, as Nathan Hershey discusses in Chapter 5.

Health care delivery is viewed as an industry in Chapters 6 and 7. As institutions are held accountable for all health care delivered within, employers are justifiably concerned with quality of care and competence of professionals. Bruce McFadden considers the interests of employers in Chapter 6.

A novel approach to credentialing is offered in Chapter 7, where an apprenticeship model for health care employees is explained by Morris Lasky. The emphasis is placed on the individual in this system. A flexible program recognizes the practitioner's needs as he or she enters and leaves the health industry. Through this personal approach, apprenticeship proponents intend to achieve quality health care delivery.

Following all this discussion and promotion of continued competence, Chapters 8 through 12 are devoted to particular methodologies. The traditional approach, that of continuing education, is addressed in Chapter 8. While acknowledging opposition to this method, Robert Derbyshire presents examples of studies demonstrating positive results from continuing education participation. After a thorough review of the evidence, the article concludes with the assertion that continuing education is essential to the continued competence of physicians.

Chapter 9 digresses from the health field to reveal another professions's approach to continued competence. The Federal Aviation Administration has an intensive program for training and re-training pilots as they advance through their careers. Ed Fell suggests that the health field would do well to learn from their example.

Technological advances play a role in the program described in Chapter 10 by Robert Burmeister. A computer-assisted model for simulating nursing home operations was develped to assist in certification. Teams of certification candidates work together in developing management skills through peer- and self-assessment.

Self-assessment receives detailed attention in Chapter 11. Ayres D'Costa discusses the components and problems of a process that features practitioners' evaluations of their own competence.

An alternative means of evaluation is practice auditing. In Chapter 12, Geraldine Ellis reports that peer review is a useful tool for assuring quality, that holds promise for continuing competence assessment.

Part Two

"Directions for Change" presents articles on a range of topics related to continued competence. Chapter 13 offers some practical information for professional groups interested in developing a program for continuing competence.

Chapters 14 and 15 reveal how two professions are approaching the issue of continuing competence. The American

Society for Medical Technology has developed a Competence Assurance System intended to ensure that professional laboratory personnel possess and use the critical elements of competence. Chapter 14 by Diana Mass highlights the role delineation, program development and monitoring system which are combined in the attempt to achieve this goal.

Pharmacy's design to assure continuing competence is depicted in Chapter 15. Samuel Kalman describes how the profession has developed standards of practice which provide a generic definition of the pharmacist's work. Through self-assessment, professionals can adapt information to their individual needs.

An interested affiliate of health care professions is the insurance industry. Third-party payors are increasingly aware of their role requiring competence on the part of health care providers. Quality performance and appropriate utilization can combine to reduce the cost of health care delivery. In Chapter 16, Daniel Thomas emphasizes the industry's goal of decreasing costs through increasing competence.

The traditional method of assuring continuing competence has been continuing education. Chapter 17 focuses on the controversy surrounding the method. Research results to date support some positions of both detractors and proponents of continuing education. Another controversial topic is professional discipline. Increasing attention is being paid to the problem of a professional's failing or refusing to participate in continued competence programs. License revocation may be an unsatisfactory solution, indicative of a profession's inability to develop more constructive mechanisms of enforcement. Chapter 18 addresses these and addresses these and related issues in urging increased attention to professional discipline.

Commission staff have reviewed many elements and issues inherent in continued competence. Their evaluation and prescription are presented in Chapter 19.

Conclusions derived from the whole of the report are presented in Chapter 20. Eight enumerated conclusions indicate paramount investigations for change.

PART ONE

PROCEEDINGS OF THE 1979 EDUCATIONAL CONFERENCE: "CONTINUING COMPETENCE ASSESSMENT - RELICENSURE - RECERTIFICATION"

Chapter 1

KEYNOTE: CONTINUING COMPETENCE AND THE CREDENTIALING OF PROFESSIONALS

by

Raymond D. Salman

I am pleased and honored to have been asked to introduce, at this important gathering, the topic of occupational regulation and its relationship with the complex and controversial issue of continuing competent practice.

It is a bit ironic that a state regulator has been designated to deliver the keynote presentation for a Commission that basically is an organization of private or voluntary certifying agencies, particularly at a time when the private sector is expressing its concern for being overburdened with government regulation. Since I am also a credentialed person, I hoped that my designation was not intended to serve as the proverbial example of why we need to address the issue of continuing competence. I was reminded of a former colleague of mine, an ex-school superintendent, who had a second career in our department. Upon his second retirement, I asked him if he didn't feel a bit useless. His wife interjected that having reached his present state of age, activity, and drive, she certainly felt he was useless. Bob immediately responded by stating that, as a matter of fact, he had great utility--everyone could use him as a bad example.

I was delighted to learn I was intended not to serve as a bad example, but rather to support the view that the issue of continuing competence is conspicuously an area requiring joint public and private efforts and commmitments.

This year's theme, "Continuing Competence Assessment," is certainly timely. It is gratifying to have such eminently qualified persons with us to address this issue. I would like to set the stage for their presentations and your workshops with a few introductory remarks.

New Era of Concern

The whole area of occupational regulation has suddenly become fair game for one and all after almost a century of neglect by consumers, legislative leaders, and others. It is no longer the exclusive domain of those who are regulated. It

It is being studied, criticized, undermined, expanded, challenged, and in some cases legislated into oblivion by economists, other scholars, state and federal agencies, the public, legislative bodies at all levels, consumer agencies, and occupational groups in conflict with one another.

Probably more than three-fourths of all reports or studies written on credentialing have been produced during the last decade. One need only review the introductory sections of many studies or reports to gain insight into the direction being taken. They include words and phrases such as "myth," "vanishing breed," "freedom," "sunset," "reform," "de-regulation," "vestigial and unjustifiable restrictions," or, as headlined in a recent article in the newsletter of the National Center for the Study of the Professions, an "issue that has come of age." (Pottinger, 1979)

One of the major reasons for the sudden interest in credentialing is concern for the competence of the credentialed practitioner. Several of my colleagues who have been pioneering adventurers in this area have remarked that the one great lesson they have learned as pioneers is that the Indians can be damned unfriendly.

Assessing Competence

The issue of competence is like a double-edged sword. There is the question of initial competence, that is, the competence of the individual at the moment of entry into practice, and secondly, the matter of continued competence.

The credentialing process is intended to assure the public that minimum standards of competence are met. Let us not be fooled--it is not an assurance of excellence. An authorization to practice a regulated occupation is not a guarantee that the practitioner is among the most competent in the field. It is recognition only that the practitioner meets those standards set by the regulatory authority below which it is felt that a person should not be admitted to practice.

Initial competence can be assessed, although the task is not an easy one. Entry into a regulated occupation requires the meeting of relevant minimum standards of education, experience, and examination performance. Any system which accommodates this three-pronged linkage is better able to assure the public that established minimum standards are met. All too frequently, regulatory authorities are equipped to establish and maintain standards in one or more of these three areas, but seldom in all. A program that enforces established educational, experiential, and examination standards in an articulated effort is highly desirable, especially if the effort is not fractionated among various agencies or groups whose interest may not always be harmonious. The centralization of authority and accountability in a single organization, particularly one that is apolitical such as the National Commission for Health Certifying Agencies, is more likely to receive public approval and support.

The test component in the assessment of competence requires the intervention of professional testing persons. It is not uncommon to find that highly trained and skilled practitioners are cognizant of areas to be tested, but are neither good item writers nor experts in test construction. The develoment of a viable examination, one that is not only reliable but relevant and meets the well-defined Equal Employment Opportunities Commission (EEOC) standards, requires expertise not usually found among the educational or practice-oriented leaders of a profession. It would be unwise for any occupational group to proceed to construct credentialing examinations in these days of truth-in-testing legislation without careful consideration of the EEOC guidelines and their impact, and guidelines promulgated by such other agencies as the Department of Justice, the Department of Labor, and the U.S. Civil Service Commission. (Federal Register, 1978) Fundamental to the construction of such an examination, and for that matter a meaningful regulatory program, is an up-to-date analysis of the job held by the examinee population. Unless a thorough job analysis by experts is the foundation upon which the regulatory program and the examination is built, the entire structure is like a "house of cards."

Beyond initial competence and entry into an occupation, there is widespread recognition of the need for at least equal emphasis on continued competence. We cannot perpetuate the self-serving myth that "once licensed means forever competent." We are in the age of requiring periodic re-assessment of some sort for continued practice. I would like to touch on a few basics in this area very briefly and without the intent to compare methodologies. Those comparisons will emerge from the presentations of my colleagues during these meetings.

Methods for Assuring Continuing Competence

The first and most popular approach to resolving this problem has been mandatory continuing education.

Unfortunately, as Dr. Cyril Houle, professor of education at the University of Chicago and a leading researcher in this area has stated, this movement was borne out of an eager directiveness and naive faith, but the "enrollment criterion" to assure continued competence just does not work, and the unknowing public is given nothing but a placebo. There is little evidence to suport the contention that mandatory continuing education has improved the delivery of services. The hypothesis that attendance in a formal program equates with learning and that the application of such learning is directly related to practice is, I believe, as yet unproven. At best it certainly is suspect. Dr. Houle has characterized the mandatory continuing education phenomenon as an ever expanding balloon that is becoming increasingly difficult to manage and on the verge of exploding. (Houle, 1977)

Peer assessment has been considered an alternative or adjunct to continuing education. Research on this approach, particularly that conducted by Dr. Christine McGuire at the Center for Educational Development, University of Illinois at the Medical Center, Chicago, has shown that peer judgments are often at odds with one another and that such efforts have been directed more toward cost containment than toward issues of competence, or, worse, have equated competence with the cost of services or length of stay in a health care facility. (McGuire, 1977) Before this approach is dismissed, however, ways to improve the reliability of peer judgments should be studied. The cost containment issue is not a basis for rejecting the concept. Its utility as a strategy for evaluating competence merits further consideration and work.

Testing for continued competence, as has been pointed out by Dr. Benjamin Shimberg, associate director of the Center for Occupational and Professional Assessment of the Educational Testing Service, is no longer the impossible dream. (Shimberg, 1977) Medicine and other professions are taking steps to deal with this issue directly. Self-assessment programs, programs utilizing patient management problems and re-certifiation procedures, both voluntary and mandatory, are now in existence. Basic to the success of such programs is the necessary development of self-assessment inventories to assist the credentialed practitioner who needs to learn of his or her areas of deficiency, if any, and what might be done to alleviate them.

'Sanctioning': An Incipient Proposal

Another, and as yet untried and not yet fully developed approach which I have been contemplating, takes into account the reality that many, if not most credentialed persons tend to narrow their scopes of practice over years. I feel the need to stress that I have not yet discussed this idea with others, even within my department. Many credentialed individuals, particularly in the health occupations move into specialty practice. Nonetheless, their authorizations to practice remain generic, despite the fact that their generic practice may have ceased years earlier and competence in certain applied areas may have diminished concurrently. With improved re-certification procedures in place in designated specialty areas and with the development of appropriate self-assessment inventories, practitioners with specialized areas of expertise might be authorized to continue a limited scope of practice without being approved for practice in other areas. I am not addressing specialty licensing but rather a system at the opposite end of the licensing continuum, a 180-degree turn. While specialty licensing may be attractive in some respects, the complexities of such a system appear to outweigh its advantages.

Instead of specialty licensing, I envision a system of generic credentialing that includes periodic re-examination. Within this system, a person may choose to limit practice, and either voluntarily or by agency demand, place a sanction on the original credential. This sanction or limitation would be based on the results of self-assessment or other measurement mechanisms. The sanction in effect would limit the scope of practice to areas in which competency can be demonstrated. At any time during a career, the practitioner so limited could be re-instated to practice in areas previously sanctioned by demonstrating competence in such areas.

Let me give you an example. A physician who practices psychiatry, whether or not certified by the American Board of Psychiatry and Neurology, may decide voluntarily to exclude obstetrics and gynecology from his practice. The generic authorization practice issued the psychiatrist would denote that limitation, which could be removed at such time as the psychiatrist chose and was able to demonstrate competence in practice. Meanwhile, continued competence in psychiatry and/or other practice areas would be demonstrated through the use of self-assessment inventories or whatever other measures may be deemed acceptable to the credentialing agency.

For the practitioner who chooses not to limit practice voluntarily, sanctions would be applied when the periodic inventories or other measures in use yielded results less than those established as minimums for competent practice in a

given area. These sanctions too could be removed upon later demonstration of competence in that area. In the meantime, practice would continue in only those areas in which competence was demonstrated. The choice of whether to seek full re-instatement to generic practice or to continue in a more limited scope would be that of the licensee.
I realize fully that I am espousing what may prove to be a costly system and one that may be administratively difficult and have probably explained the idea in an over-simplified way. But, I believe the idea may merit further exploration and would welcome your thoughts and comments.

Traps To Avoid

I have tried to pose in a broad way the problems at hand and some efforts at resolution. Now let me make a few remarks about pitfalls I think we must avoid in developing strategies for assuring continuing competence.

Probably the most dangerous pitfall is the failure to recognize that a credential earned when one begins a career may bear little direct relationship to the skills of the practitioner years later. Technologies develop and change, and individuals may either narrow or expand their scopes of practice. Furthermore, a job analysis of an occupation at the entry level need not necessarily relate to common practice after five, ten, or more years in the field.

A second pitfall to avoid is the implementation of programs for assuring continued competence that are unlikely to yield favorable results despite being well-intentioned. The process should not mislead the public into a false sense of security. After all, the primary beneficiaries of any programmatic changes we implement should not be the professionals themselves. The program should yield measurable outcomes.

A third is the myth that effective, viable programs in this area will probably diminish the need for vigorous disciplinary programs by credentialing agencies. Of course, sound and thorough evaluation programs at the entry level and programs to assure or encourage continuing competence reduce the need for post-credentialing removal of incompetent practitioners. But, these efforts will not of themselves minimize the need for effective and rapid removal of practitioners found guilty of unprofessional or incompetent practice in the delivery of services. A strong commitment to the disciplinary process is essential.

Finally, we must avoid a strategy of delay and inaction. There is no question that re-certification or re-licensure proposals face both political and psychological barriers. But, if the occupations themselves do not assist in taking the steps necessary to assure the public that credentialed practitioners maintain or improve their skills after entering practice, the occupations will face pressures from consumers and others for either more restrictive regulation to assure a greater measure of competence or, at the other end of the scale, total de-regulation. Either may be impossible to bear.

Taking Responsibility

One fact is irrefutable. The basis for credentialing has been the assumption that a credential has a quality component, that it translates loosely into an assurance to the public of quality services. In recent years, Houle has reported (and I concur) that such is no longer fact: that because of widespread, even dramatic demonstrations of incompetence or aggressive self-interest, credentialed professionals have come into collective disrepute, and have fallen low in public esteem. (Houle, 1977)

To reverse this trend, professional associations and certifying agencies working together must accept responsibility for quality control and must exercise lead authority in assuring both the initial and continued competence of professionals. This need is not new, although in the area of continuing competence assessment, there does not yet seem to be a great deal of expertise to go around. Much of the expertise is here with us today. You have the opportunity to share with them your own ideas, experiences, and perspectives through participation in this forum. After all, you also will share in the responsibilities that will change as the credentialing systems change. On this issue, your own continuing competence, as leaders, is at stake.

Chapter 1

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Chapter 2

AN EXPERIMENTAL APPROACH TO COMPETENCE ASSURANCE: THE MICHIGAN EXPERIENCE

by

Eugenia S. Carpenter

Today I will be discussing with you an approach to the issue of continuing competency taken in my own state of Michigan, an approach I termed "experimental." Michigan's competency policy is embedded in a broader reform of health occupational licensure which went into effect on October 1, 1978, after a gestation period of more than four years.

The approach taken in Michigan to the problem of assuring the continued professional competence of health practitioners as a condition for relicensure is, I believe, unique. Michigan's new Public Health Code authorizes all affected health boards to undertake pilot programs to develop mechanisms for assessing continued competence. The Health Occupations Council, a coordinating and advisory body newly created under the code, is mandated to study the programs developed by the individual boards and to study other approaches to achieve the objectives of periodic assessment of continuing competency. Within a six-year period the Council must evaluate existing public and private mechanisms for competency assessment and make recommendations for statutory changes that may be needed to implement the findings and conclusions of the study. The legislative mandate is unusual in that health boards and the umbrella agency within which they are located, the Michigan Department of Licensing and Regulation, are being asked to engage in a six-year experiment to identify, test, and evaluate ways of assuring that health professionals maintain acceptable levels of competency over their professional lifetimes.

The Michigan approach to the competency issue can best be understood within the context of the broader reform of which it was a part. The restructuring of health occupations licensure might itself be looked upon as a kind of experiment, since it seeks to determine whether such restructuring can achieve the twin and sometimes conflicting goals of quality assurance and cost effectiveness of health services.

Legislative History

Michigan's reform of its public health laws began in 1974 with the appointment by Governor William Milliken of a Commission on Public Health Statute Revision, composed of consumers and providers of health care services. At the same time, the Michigan legislature established a Legislative Council Committee on Public Health Statute Revision which, together with the Council, formed the Public Health Statute Revision Project (PHSRP). The organization of the project thus provided a forum in which consumers, health care providers, and members of the legislature could identify, analyze, and debate approaches to the reform of health statutes. The project set up six technical work groups to deal with substantive areas to be included in the code.

The Health Manpower Work Group, which I chaired, very early took the position that occupational licensing laws were appropriately within the purview of public health statute reform. Moreover, it quickly became apparent that this was an area of great need for recodification, consolidation, and new policy directions.

I am sure that most of you in this audience can appreciate the complicated and delicate political negotiations that were required to accomplish a synoptic reform of health occupations licensing, which finally encompassed 12 areas of health practice, including 17 separate occupations. In retrospect, it seems somewhat miraculous that we achieved this kind of reform while maintaining to a considerable degree the integrity of the proposals which were conceived in the course of the prelegislative phase. Several factors can be seen to have influenced this outcome.

First, the unique composition of the project, which I described earlier, provided a direct linkage from the analytic, advisory component, to the legislative phase. Another important factor was the analytic approach taken to the development of proposals. Each generic issue of occupational licensure was analyzed, the provisions of then existing law tabulated and compared across the health occupations under review and recommended alternative approaches to reform presented. The issues were debated at the workgroup level and at the project level with input sought from interested parties. The project not only made recommendations, but actually drafted the statute.

The involvement of interested publics through meetings and eight public forums contributed to the success of the project. The creation of a lobbying group for the code brought continued involvement of those who had been involved in developing the legislation. The fact that it took two years and one month following the introduction of the original bill to enact the code demonstrates that even all of these careful preparations did not assure ease of legislative enactment.

The Continuing Education Issue

The principal concerns that were raised related to amendements proposed by the representatives of medicine and osteopathic medicine to make the continuing education provisions consonant with the standards proposed by their national associations, i.e., a 50-hour, three-year standard. During the legislative deliberation on the code, these amendments were adopted. It should be noted that the continuing education provisions which were carried forward were made discretionary rather than mandatory and that authorization to use alternative approaches to assess competency were included in the provisions relating to the five areas of practice. Nevertheless, the amount of effort expended by the professional groups who sought to modify these continuing education provisions suggests that the concept of continuing competency was equated in the minds of many observers with traditional continuing education approaches.

The Continued Competency Issue

The issues surrounding assessment of continuing competency were not areas of high visibility or conflict during either the prelegislative or legislative phases of the creation of the code. The position of the Public Health Satute Revision Project on this issue was, however, quite clear. It may best be summarized by quoting from a 1975 position paper which became the basis for the statutory provisions for the pilot programs and study of continuing competency that were subsequently mandated in the code:

> While there is growing awareness of the need to assure the continuing competence of licensed health professionals, the effectiveness of existing and proposed measures of such competence has not been demonstrated. Rather than mandating extension of the only measure now currently affecting some professions, e.g., continuing education, it seems more reasonable to assess with some rigor

> this approach as well as others that have been proposed. It is premature to propose a definitive solution to the continuing competence problem without further, serious study. Michigan has the opportunity to assure a pioneering role in this area.

In brief, the intent of authorization for pilot programs by boards and the mandating of the study of these programs and alternative approaches was to preclude an *a priori* judgment to the efficacy of any given approach to assessing continuing competence of health occuations licensees.

While continuing competency provisions of the health occupations article were of relatively low visibility in the political process, there has been a growing awareness of the significance of continuing competency as distinguished from continuing education. It is also important to note that this increased awareness has been accompanied by growing recognition of the complexities and difficulties of the problems and issues involved in developing a viable state strategy for assessing and assuring the continued competence of licensed health workers.

Status Report

The competency studies committee of the Health Occupations Council has thus far been engaged chiefly in informational and data gathering activities. Requests have gone to all of the licensing boards covered under the Health Occupations Article requesting information about their plans and programs for implementing the continuing competency provisions. In addition, the committee has met with representatives of several of the professions who are developing new approaches to competency assessment.

Looking ahead, Michigan's grand experiment in competency assessment will have to reach some kind of conclusion by October 1, 1984. My professional member colleagues on the Health Occupations Council have indicated that awareness of the issue is much more prevalent since the establishment of a Council and the recognition of the far reaching changes incorporated in the new code. Moreover, comments have been made which indicate a growing recognition that *pro forma* continuing education provides a kind of false security to the public and to the practitioner.

Even among those most committed to the concept of a responsible and accountable system of competency assessment, there is recognition of the formidable, technical barriers to developing a system which is effective in terms of assuring the quality of health care services provided by licensees. It is also recognized that even if these technical problems can be overcome, the costs of an effective system may be excessive to the practitioners, the providers of health care, and to the public.

The technical problems of developing a system of continuing competency assessment may be described very simply as those of: (1) defining the meaning of a minimally acceptable level of competency, and (2) devising means to measure those levels. Since this conference will be largely devoted to those issues, I will not discuss them further here.

Turning to the issues relating to cost and effectiveness of various approaches, I believe the issues can be categorized into five areas: costs, including both developmental and operational; effect on quality of care; acceptability; administrative feasibility; and types of measures. An approach which may have relatively high developmental costs, for example, developing a system of re-examination, may have relatively low operational costs, as is indeed the case with the examination approach. Similarly, the effect on the quality of health care of different modalities may vary widely, and the assessment of this aspect must be part of any evaluation.

The acceptability of a programmatic approach is clearly important if its goals are to be realized. This means that the approach must have the endorsement and the cooperation of the practitioners in the profession involved, and must also have sufficient credibility to be acceptable to the public at large.

Recommendations

A final point I would like to make is that it is my view that the issue of competency assessment as linked to state licensing of the health occupations must be viewed in context of the total system of health personnel regulation. It would be my recommendation to other states that were seeking to emulate Michigan's approach or to develop other legislative responses to these policy issues to consider the interacting components of personnel licensure which affect and are affected by the competency issue. If indeed better methods of assessing continuing competency can be developed, surely these will have some impact on the means by which states currently devise measures of initial competence. The establishment of an ongoing system of periodic reassessment of the competency of licensees should also remove the arguments of highly restrictive barriers to entrance from out of state.

The continuing competency issue has implications for the "all or nothing" school of occupational licensure. It would be unfortunate if the effect of a competency assurance program were to bar from practice persons who were competent to function within more circumscribed areas of practice or under certain conditions of supervision or surveillance because such individuals fail to meet the competency standard for full and unrestricted practice of the occupation. Therefore, if one is interested in constructing a responsible approach to competency assessment, it would seem necessary and desirable to develop a concept of flexibility in types of licenses.

Finally, the social and political pressures for developing lifetime competency assurance as a part of health personnel regulation are but a part of the general skepticism about the efficacy of traditional licensing mechanisms that has become evident over the past decade at least. Licensing agencies will need to improve their monitoring and regulating of performance if they are to respond to the demands for greater public accountability of the process.

If the monitoring and sanction cabability of licensure agencies were to be significantly improved, it is conceivable that this development would dampen pressures for the integration of competency assessment into state licensure systems. The issue would then return to the private sector, to the professional associations where it originated. There is certainly significant support within the purview of the professionals themselves. If that were the case, one might also speculate that alternatives to the current system of individual licensure for health practrice might gain wider support.

For today, it is sufficient to be faced with the challenge of constructing a responsible and effective structure for assessing the competency of licensed health practitioners.

Chapter 3

A FEDERAL PERSPECTIVE

by

Thomas D. Hatch

If health manpower credentialing is to be rational and meaningful and do those things it was created to do--protect the public and assure the competence of health workers--we must have some means of assuring competence on a continuing basis and making this assurance part of the credentialing process.

Continuing Competence and Continuing Education

Some years ago, a number of us in the health field might have accepted the proposition that assurance of continued competence means continuing education. Few, I think, would now accept that proposition uncritically, primarily because continuing education means different things to different people. We must continue to make the distinction between two types of "continuing education":

(1) Programs designed to assure that health practioners maintain performance at a basic level of professional competence; and

(2) Programs designed to assist professionals obtain advanced training and specialized skills beyond those required at the basic professional level.

When relicensure or recertification is involved, we really need to define "continuing education" in the first of these senses and apply several basic ideas in attempting to develop mechanisms and policies. Requirements for recertification or relicensure must be based on changes in the concepts and technologies of the professions and closely related to the basic requirements for entrance into the professions.

In cases where recertification or relicensure is involved, programs of education and training must be reasonably accessible to practitioners, particularly if a specified amount of education and training is required.

The Need for Objective Evaluation

Approaches to continuing competence may include peer review through Professional Standards Review Organizations, re-examinations, self-assessment techniques, and supervisory assessments, as well as continuing education. There are several points that need to be kept in mind as we approach the issue of relicensure or recertification. There must be a means of identifying the necessary and appropriate knowledge and practice skills, and a means of collecting acceptable, reasonably objective evidence of these at suitable intervals.

A clearly delineated standard is needed to protect the practitioner as well as the consumer of health services, and, I would argue, a criterion-referenced standard is as important for the assessment of continued competence as it is for assessment of entry-level capability.

Assurance of continued competence means that evaluation is conducted at some regular interval. The interval may vary among professions, but there should be some reasonable and rational means of deciding what "current competence" is, how it can most effectively be measured, and how often it should be evaluated.

The development of formal or informal specialties has already or will at some point in the future pose serious and complex questions for virtually every profession. These questions will require extremely careful study.

Possibly the most difficult issue to address is that of discipline. As a profession engages in recertification or relicensure, it will need to develop some means of dealing with individuals who do not measure up to the standards adopted. In balancing fairness to the practitioner with protection of the public, at what point should an individual be judged incompetent and barred from practice or from maintaining certification?

The task of establishing and implementing a reasonable set of standards and procedures for assuring the competence of health personnel is not an easy one. Yet, the existence of this Commission and the efforts involved in planning and conducting programs such as this are very encouraging signs.

Chapter 4

RECERTIFICATION OF PHYSICIANS--A STATUS REPORT

by

Glen R. Leymaster

I am pleased to be invited to discuss with you the activities of the American Board of Medical Specialties and its 23 member physician certifying boards in the area of recertification. Our experiences may be helpful to you as you re-evaluate your activities in licensure, certification and recertification. You may be able to profit from our examples, experiences, and mistakes.

On September 20, 1978, the American Board of Medical Specialties held a day-long conference to review the status of recertification. A comprehensive report was prepared; I am able to offer you a report of that conference.* The report deals mainly with the present status of specialty board recertification but touches on the historical development, the relationship to relicensure and future plans of the physicians' specialty boards.

Terminology Defined

It may be desirable to define a term or two as usage may vary. Licensure is a governmental activity, a state activity giving the physician the right to practice medicine. It is concerned with minimal standards of qualification and, within limits, of competence. Relicensure, or more accurately re-registration of license, is the renewal of that right based on a variety of state-imposed activities, most commonly mandatory continuing medical education. Although considered, no state presently includes re-examination as a requirement for relicensure. Nine states will accept recertification (which does require examination) in whole or in part in lieu of the educational requirements for re-registration.

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* A copy of the Conference on Recertification report is available by writing to ABMS/1603 Orrington Avenue/ Evanston, IL 60201.

Many of the states will grant a license to practice medicine with no training beyond medical school. These governmental requirements are far too permissive. This statement should not be construed to mean that effective controls are lacking, however. Hospital regulations, malpractice insurance and awareness of one's own limitations combine to provide effective controls.

On the other hand, certification is non-governmental, is voluntary, and by itself confers no rights or privileges. It is concerned with superior standards of performance. Certification signifies that the physician has completed a prescribed training program beyond medical school of three to seven years and has voluntarily submitted to the examination and evaluation by peers. Thus, certification is an important qualification implying special competence but is not a sole qualification for special privileges. Likewise, the lack of a certificate in and of itself should not exclude an otherwise qualified physician from any phase or kind of practice.

I define these terms because certification, to some of you, may be more akin to our licensure than to our certification. In the following discussion, I use "recertification" to refer to periodic renewal of physicians' specialty certificates.

Physicians as Leaders

I am proud to say that the initiative for the recertification movement has been with the physicians since at least 1920. Since then, the profession has repeatedly expressed the perceived need to maintain and improve competence through self-education. This is not to deny that the position of the profession's leaders has been significantly strengthened by public concern about physicians' continuing competence. In recent years, the consumer movement has repeatedly demanded evidence of continuing physician competence. Assurance has been provided by many medical societies and associations which have required continuing education as a qualification for membership, the medical licensing boards which have required continuing education to maintain a license to practice, and, most recently, by the specialty boards which have developed a variety of programs of recertification which include a variable mixture of education, practice evaluation, and examination. Typically, the recertification program is voluntary, but in a few cases, it is or will be mandatory.

ABMS Guideline

The ABMS is a federation of the 23 physician certifying boards. In 1975 it adopted a 10-part Guideline to Recertification which was revised in 1978. Each board has committed itself to a program of recertification which is contingent upon ABMS approval. Nine programs have thus far been approved. Pertinent Guideline excerpts follow:

#1: Recertification should assure through periodic evaluation the physicians' continuing competence in the chosen area of specialty practice.

#2: Recertification should require certified physicians to continue those educational activities essential to the maintenance of competency in their specialty.

#3: It is the prerogative of individual boards to elect voluntary or mandatory recertification; however, a specialty board may not rescind initial certificates by recertification procedures unless a date of expiration was a condition of the original certification.

#4: Similar intervals for recertification by the specialty boards are desirable; an appropriate interval appears to be (at least) six years but not more than ten.

#7: Member boards are encouraged to develop procedures for recertification that are most appropriate to the characteristics of their specialty practice. Participants in continuing education, skills and performance evaluations, practice audits and practice profiles are among the elements that should be considered. The recertification process must also include measurements which are directed toward evaluating the candidate's ability.

#10: The design of recertification procedures requires close collaboration between specialty boards and their specialty societies and other constituencies; however, the determination of policies and procedures affecting the recertification is ultimately the responsibility of each board.

I want to emphasize that these guidelines:

(a) provide for a recertification program adapted to the physicians' practice,

(b) stress the importance of education in maintenance of competence, and

(c) provide optional attention to continuing education skills and performance evaluations, practice audits and practice profiles, but demand measurements directed toward evaluating the candidates' ability.

I perceive an important element of the recertification programs to be in their indicating to the consumer (the public) that the medical profession is moving to provide assurance of continuing physician competence. The incontrovertible fact that the program is not perfect should not deter us from a program that is progressive and useful. We cannot reach all the impaired physicians; we can, however, identify those who are industriously trying to maintain standards, who are conscientious, and who have updated the "learned" component of a learned profession. For the moment, that recommendation is good enough.

I believe that given continuing good will, a modicum of flexibility of standards, and a little time, each of the boards will move ahead and ultimately develop an acceptable program for recertification.

Chapter 5

SELECTED LEGAL CONSIDERATIONS

by

Nathan Hershey

The Burden on Recertification

The title of this general session tells us that the focus of concern is on continuing competence. A very important factor is implied by this focus. Requirements for recertification, in order to survive legal tests brought by those who do not meet the requirements, not only must be rooted firmly in the knowledge, skills, or characteristics needed for an individual's actual on-the-job performance, but also must be no harsher than the requirements for initial certification. This is because, although it may not be explicit in the law in many circumstances, it is generally perceived to be more harmful to take away something from a person that has already been granted than to refuse to grant something that the person initially seeks.

Even if this distinction between entry-level and mid-career credentialing is not clearly reflected, the distinction may well affect the burden that must be met in a particular instance. For example, it would appear that for initial approval of any kind, the applicant has the burden of showing that he or she has met the basic requirements. With respect to re-approval after a period of time has elapsed, the burden shifts to those who conduct the approval process to show why the individual is no longer deserving of the approval previously granted.

We see this distinction particularly clearly in the area of medical staff appointments today. If one takes a look at a set of modern medical staff bylaws for a hospital, there is language about the burden being on the physician to show or demonstrate that he or she is qualified for medical staff appointment. On the other hand, to a certain extent, one finds language, with regard to the re-appointment process, or in terms of taking disciplinary action, that there is a burden of coming forward with a reason for, or facts to support, a negative recommendation that would take away the appointment or privileges the physician gained some time earlier.

A Scenario

Allow me to lay out a scenario to illustrate the importance of this distinction to certifying bodies. Consider the case of an individual who has received certification from one of the Commission's member organizations based in part on successful completion of an examination. Assume that the examination was determined to be both valid and reliable, and that no serious questions could be entertained with respect to its serving the purpose for which it was intended. The individual, armed with the certification, seeks employment in a health care institution. The institution's personnel department reviews the individual's application and notes that the individual has been certified in an area for which employment is available, and so the person is hired for the position of technician or therapist, or in some other capacity. The individual's performance is adequate on the job; the individual has been granted pay raises during the course of employment because of satisfactory performance. Also assume that it initially, or later, was written into the position qualifications that the individual who holds the position must be certified. After a period of time has elapsed, the individual now needs, according to the rules of the certifying organization, to secure recertification. The individual submits to the recertification determination process and is notified at some later date that he or she has not retained certified status.

Now we face questions concerning not only the responsibility of the certifying agency, but also the relationship between its role and the continued employment of the individual by the employer. Obviously, the organizations represented here want their credentials to be utilized; such recognition makes certification important. But, importance of that sort brings with it attendant responsibility.

If the employing institution learns that the individual has failed to maintain certified status, the employer then must decide whether to terminate the employee, even though performance on the job has been satisfactory ever since employment began. We can introduce into this situation the possibility that the state hospital licensing agency, or the state department of health, has provided in its regulations that individuals who perform certain duties must be certified, or an even more lenient provision that requires that they be certified or otherwise have been determined to be qualified by some process to carry out the duties of the position. The employer may take the position, that even though the record has shown satisfactory performance on the job, because a certifying process--the possession of a ticket--is such a simple, pass-fail test to use in employment matters, it will apply the certification criterion and terminate the employee's work opportunity. Certainly, if state law or regulation requires that the person be certified to hold the position, the employer has little or no discretion to exercise.

If the employee is terminated, or even threatened with termination, we have a disgruntled person who is likely to seek legal assistance. He or she would probably be advised by an attorney to determine what appeal procedures are provided by the certifying organization, and the attorney would assist the individual in following them. It might be possible to challenge at this stage the job-relatedness of the certifying agency's criteria or evaluative process. In relation to this, the question can be raised with respect to whether the employee, or ex-employee, is as qualified as an individual who has just completed the certifying process for the first time. If the individual in our illustration is as well-qualified for certified status as an entrant to the field who has just received initial certification, the unfairness present in this situation is obvious, and an approach to the courts may well be considered at this stage. Private organizations may assume public responsibility because of their activities, and there is a line of cases in the health field that indicates the courts have intervened if action by such an organization is arbitrary or capricious. The facts I have assumed so far make a tenable argument for a finding of capriciousness.

Modifying the Scenario

There are additional factors regarding job-relatedness that go to the somewhat unique situation of the position within the employing institution. There is a process in most institutions whereby the scope of tasks and related judgments for employees is modified over the course of time in the interest of more efficiency, better division of labor, etc., to fulfill the institutional needs. Assume that our illustrative employee held a position that had been expanded or modified, so that it came to include other duties than those for which certification was pertinent. Thus, in challenging the process of the certifying agency and/or the requirement of the employer that the individual be certified, the employee's position would be even stronger if all the skills examined through certification are no longer needed for the particular position and if certain other skills, not within the scope of the certified occupation, are required by that individual.

Today the law is not particularly clear with respect to the availability of a remedy for employees who would be faced with the loss of jobs for failure to maintain certified status. But, the individual's position would be greatly enhanced if he or she were a member of a minority group, and the recertification process resulted in a disproportionate number of members of the minority group failing to maintain certified status and thereby losing their opportunities for continued employment.

The basic scenario I have been using can be modified further to encompass a situation where the employee is a member of a labor union that has a collective bargaining agreement with an employer. From my brief experience in the practice of labor law more than 20 years ago, and from what I have read since, it would strike me that few unions would accept termination of employment of a member based on failure to achieve recertified status, and this is almost certain to be the case where the reports of job performance have been satisfactory up to the date when the person was denied recertification and was faced with consequent loss of employment, absent a mandatory state legal requirement of certification.

The Prospect of Legal Intervention

I think that the implications of this scenario are obvious. Once an individual is employed and has produced a record of job performance, it is that performance, rather than anything a certifying agency may issue, that is appropriate for maintenance of employment. If the certifying agency has the opportunity to control employment in a profession or occupation, it may come under the scrutiny of the Federal Trade Commission (FTC) or some other government body, which might take the position that the recertification process raises issues with which it is fundamentally concerned and over which it has jurisdiction. While my opinion is that the certification process and private certifying agencies are beyond the FTC's legal jurisdiction, there may be some who would disagree with me.

A few recent court decisions have indicated that the courts will consider whether an employee who has been terminated, even if the employee had a contract terminable at will, suffered termination through a process that is perceived to be contrary to public policy and is therefore entitled to relief from the courts. There has been a decision in New Jersey (O'Sullivan v. Mallon), involving a somewhat different fact situation, which states that the court will take cognizance of the facts leading to discharge, even though the contract of employment was, as a legal matter, terminable at will and, in theory, strictly within the discretion of the employer. That case involved the termination of an employee, a technician, by a hospital. This technician was asked to perform health care services that were clearly covered by a state mandatory licensing law for a particular kind of health service worker. The employee was not a licensee, and she objected to carrying out the order on the basis that she was being asked to perform an illegal act. The court said she had basis a for suit.

Another case in New Jersey (Pierce v. Ortho Pharmaceutical Corp.) involved the termination of a professional employee who lost her job because she would not do something that she asserted was unethical. The employee in question worked for a drug firm and was put under severe pressure to approve a product, before what that employee felt were the necessary evaluative procedures regarding a company product had been completed. The court ruled that she had a basis for suit.

Although it is a substantial jump, it would not be, to my mind at least, a revolutionary step for a court to look into the question of the termination of an employee because he or she has lost certification when the evaluative process to determine "continued competence" was different from the test or other evaluation procedure used for new entrants into the area of activity for which certification is granted, and the employee could establish, or sought the opportunity to establish, that he or she could meet the standards for initial certification.

The Need to Justify the Evaluative Process

In short, what I am saying is that a current employee who successfully completed the hurdles for initial certification may have a very good argument if he or she is denied certification or continued employment, because he or she has not passed the hurdles of continued competence in order to maintain certification. That does not even reach the question of whether the relationship between the evaluation process for recertification and job performance is substantial.

Some of the more suspicious among you may believe that I have developed my argument so that I could carry my views against licensure into the certification arena, or at least with respect to continued competence evaluation in the context of recertification. But, if standardized tests or other standardized mechanisms are employed in recertification, and others are using them to affect important rights or interests, responsibility for adverse effects cannot be ignored. That certification conducted in certain ways may have some of the illogic of much professional and occupational licensure is a question that you may want to ponder at length.

In conclusion, let me try to tie the threads together. If a certifying agency is successful, in the sense that its credential is accepted widely, it will be subject to scrutiny in respect to the fairness and appropriateness of its processes, because it may well affect the rights and interests of those who fail to secure certification. Such scrutiny may come to the courts in specific litigation, or from one or more public agencies concerned about the effects of actions by the certifying agency or, eventually, from legislatures that seek to curtail the power of the certifying agency because of the impact that it has. If a certifying agency's primary concern is to control the supply in an occupational area or serve other interests of the certified persons, rather than the altruistic one of public protection, and such motivation becomes apparent because of the processes used by the agency, then legal problems will be substantial if the agency's credential is widely relied upon to the detriment of some.

As an attorney, I think that a vital role for the Commission is to keep certifying agencies on the ball--to press you to comport with due process in your procedures and to be able to justify your evaluative processes. Then, we can worry about whether the National Commission's own procedures fulfill basic due process requirements and whether the evaluation of applicant and member certifying agencies is sound.

Chapter 5

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Chapter 6

AN EMPLOYER'S CONCERN

by

G. Bruce McFadden

Accountability and the Costs of Care

Health expenditures in the United States are approaching a level of $200 billion per year. You may read about it in the *New York Times*, the *Wall Street Journal*, in professional journals, and even in the *Federal Register*. Of that hardly modest sum, it is anticipated that hospitals will expend some 40 percent or more.

The past century has generated excitement and achievement unparalleled in the history of health care. This achievement has not come without cost. The cost now approximates 10 percent of the gross national product of the United States.

Still, past achievements may become overshadowed by events during the next 100 years. It is quite questionable, however, whether this nation will allow another doubling of its gross national product's proportional contribution to health during the upcoming century. The continuation of great progress in health care is likely to depend in large measure on our ability to assure cost-effectiveness and the attainment of high benefits at controlled costs in the delivery of health services.

Today, cost concerns are focused on the institutional delivery of health services. The concern emanates not so much from the general public, but instead from politicians, bureaucrats at all levels, and big business, all of which are growing increasingly alarmed at the amount of expenditures dedicated to the delivery of health services. As we move into a period when total annual health expenditures increase well beyond the $200 billion level--of which 40 percent or more goes for hospital care--expectations of accountability will continue to grow. Greater public disclosure will be expected and demanded. Regulatory involvement will increase. The regulatory effort will be directed toward hospitals, where a focus of institutional accountability can be established, maintained, and controlled.

The Employer Perspective

I am an employer. My institution employs 2,900 persons with a direct salary cost of some $40 million this year. I am concerned about costs in the health care delivery system, particularly about manpower expenditures and the productivity which relates to these expenditures. One of my concerns as an employer is the available supply of manpower--not only in terms of quantity but also in terms of quality.

To date, institutions and professional organizations have been the most powerful determinant of the quality of health manpower. The quality has been measured retrospectively through various forms of assessment. Design characteristics usually have been reasonably simple and straightforward in establishing criteria and minimal standards for manpower. It appears evident that such a period is now past.

As an employer, I conclude that the recent initiative of the federal government to establish mandatory criteria for laboratory personnel is no more than regulatory involvement at the front end, which establishes complex criteria and organizational requirements with little or no outcome or competence measurement involved. Such accountability, based on somewhat artificial requirements, lends itself to increasing managerial complexity and difficulty factors without addressing the issues of manpower competence, manpower productivity, or outcomes of quality and quantity.

The Importance of Voluntary Action

A brief description of relevant terms may help to clarify the fundamental issues underlying accountability for competence. Competencies are defined as identified and assessable behaviors or behavioral indicators, reflective or requisite professional knowledge, performance skills, therapeutic applications, and attitudes.(Broski, 1977) Licensure and certification, both of which suggest competence, differ from each other. Licensure implies official government involvement, while certification may be an extension of a formal educational program and/or involved professional societies or organizations.

In my view, the marked success of health care in this country relates to its voluntary system. Although government resources have been used to assist the voluntary effort, it has been a basically unregulated health industry that has provided advancements for the nation as a whole. In whatever manner continuing competence may be measured, it seems to me extremely important that the initiative be of a voluntary nature.

If voluntary initiative is to remain in our hands, that initiative must be energized today. A void in the arena of voluntary competence assurance invites government intervention.

A Window on the Future

In the future we may see a replacement of credentials based on educational experience with a certification of competencies in the various disciplines. There are barriers to such change, however. The emphasis on an individual's being able and free to perform upon completion of an educational program is strongly entrenched. Current mechanisms of individual and institutional accountability for actions and maintenance of professional standards are related to the competence-based education philosophy.

The professions are also moving toward mandatory continuing education. The primary goal is to assure that practitioners will maintain their competencies. However, many continuing education programs fall short of this goal. In a recent article, R.M. Conant advises the health professions to begin serious consideration of a competence-based re-credentialing process at regular intervals, noting that continuing education programs do not assure competence.(Conant, 1977)

These requirements of certification and continuing education should influence the economic aspects of health and health care delivery dramatically. Individuals required to undergo a greater amount of evaluation and to participate in life-long education can be expected to demand more compensation for their time, energy, and demonstrations of competence. Economic bargaining, as a result of these influences, will in turn escalate expenditures in health, which will again invite government intervention and direct involvement in the competence arena.

The Role of Institutions

I would like to spend a moment on the subject of institutional accountability. As I have mentioned and as you certainly are aware, the issue of accountability has led to dramatic change in institutional life. Today, institutions are accountable for all that transpires within their walls. There are currently on the books legal precedents that establish such responsibility. Hospital governing bodies no longer are protected under the old common law, but now are legally responsible for the care delivered in their institutions. Such responsibility includes manpower performance, be it that of a physician, nurse, technologist, technician, or member of another personnel category.

If an institution has such legal accountability, should it not also have the authority to establish competence levels? If independent agencies are to be involved in competence measurement, what then becomes their legal accountability, and in what manner is institutional accountability affected? Should institutions be involved in licensure, certification, and the continuing assessment of competence, or should this be an independent, voluntary process with commensurate responsibility?

The American Hospital Association, like yourselves, has been concerned about competence for some time. In developing "guidelines" which its members might use, along with legislators and others faced with requests for licensure and certification, the AHA's special committee noted the great importance of manpower competence, continuing competence, and the need to move forward with definitions and measurements of continuing competence. This special committee--composed of multiple professions, the American Medical Association (AMA), and institutional representation--recognized that dealing with this question would be very difficult.

The AHA's Council on Manpower has recommended that the accreditation of educational programs should remain in the voluntary sector. Similarly, although a high margin of difficulty exists, recognition of the voluntary sector's existing capability would indicate that it is indeed far better prepared than the public sector to develop and undertake approaches to competence assessment and assurance for health manpower.

In summary, employers' concerns focus on the economic aspects of health and health care in terms of supply and demand, and expenditures. The concerns focus on competence, performance, and productivity. And finally, they focus on overall accountability in this process.

Chapter 6

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Chapter 7

AN APPRENTICESHIP APPROACH

by

Morris Lasky

Building Competence Through Apprenticeship

My focus this morning is on apprenticeship as a means of promoting or expanding competence. In 1977, the Bureau of Apprenticeship Training of the U.S. Department of Labor and the Service Employees International Union began to cooperate to develop new initiatives for the application of the apprenticeship model to non-traditional occupations within essential industries, including the health care fields. The Service Employees International Union includes approximately 250,000 health care workers in its membership. We were intrigued by the possibilities of introducing the apprenticeship model into health care.

We began our work with an assessment of health manpower. We found troubling conditions in many areas. The nursing profession is a prime example. Some of the inner city hospitals with which we work are in a state of near-crisis due to severe shortages of registered nurses. In some, the annual turnover rate for RNs is over 35 percent. Yet, in sharp contrast, in the same facilities, the licensed practical nurse pool is a relatively stable work force. Despite the desire and the willingness to upgrade themselves, and despite the fact that if they were upgraded they would provide a stable means for filling the community's critical shortages of nurses, these LPNs lack the opportunity to achieve registered nurse status. They lack access into any career development system and the means for career mobility, because they cannot afford formal education that would require foregoing full-time employment for an extended period of schooling.

Regardless of the degree to which health care is made more technologic, it still must be delivered by people. The skill and effectiveness with which people deliver care depends directly on the quality of their training and education. To put it simply, the health care field is labor-intensive.

Our program seeks to provide access to a system of career development and mobility that is affordable and appropriate to the needs of those for whom the established routes are generally not available. We have designed a module format with multiple points of entry and exit. This format enables the individual to proceed as far as he or she can go and at a pace consistent with personal desires, abilities, and circumstances. Credit is granted for previous knowledge and demonstrated skill, regardless of the means by which they were acquired.

Expectations for a New Methodology

We hope to institutionalize a system of continuing education and advancement with a built-in process of continuing competence assessment. We intend to design the system in ways that will provide alternative paths of access and opportunities where none now exists.

We realize that there is always some initial resistance to change in methodology, but it can be overcome. I caution you not to underestimate the strength of our commitment. We will not be dissuaded from our own advocacy on behalf of those persons whom we represent and who deliver health services.

Apprenticeship is a model that blends theory and practice and is itself a method of competence assessment. It is a model based on performance. Apprenticeship is also based on standards of quality and therefore is itself a form of certification.

As we enter the next stage of our project in 1980, we will be testing, perfecting, and implementing this model. We will welcome your criticisms and your counsel as we proceed. We think that it is in the mutual interests of employers, unions, and certifying agencies to keep an open mind and to discard no methodology.

Chapter 8

CONTINUING MEDICAL EDUCATION

by

Robert C. Derbyshire

Continuing education for health professionals, especially physicians, is a concept that has been realized. My purpose here is to point out some of the landmarks reached in realizing this concept in recent years. I also will discuss the necessity for continuing medical education.

Competence and Education

To begin with, a working definition of competence is in order. While most people believe that they know what is meant by the term, a simple dictionary definition is insufficient, particularly as applied to medicine. In 1974 the Coordinating Council on Medical Education appointed a Committee on the Continuing Competence of Physicians (Committee Report, 1978). The members realized that their first task must be to define competence. The committee concluded that "physician competence is the function of an array of attributes which compose a pattern of effective activity directed toward the health and well-being of people as individuals or as groups." The committee identified three essential dimensions encompassing knowledge, abilities, and clinical judgment. Included under abilities are communication skills, technical skills, self-discipline, work habits, and professional attitudes. Clinical judgement is defined in part as the "capacity to apply the appropriate knowledge and skills at the right time." I submit that this is an excellent working definition. However, a physician, who lacks one or more of these attributes is not necessarily incompetent; for example, communications skills might not be important to a pathologist.

If we agree with this definition, must we also not agree that knowledge is the foundation on which all other attributes must be built? And, should we not specify that knowledge must be kept up to date or it is worthless? Finally, should not we agree that continuing education, by whatever means obtained, is the only way to keep knowledge current? This is important in view of the estimate of several authorities that the half-life of medical knowledge is five to six years.

Early Efforts at Mandatory Requirements

In view of the current explosion of medical knowledge, it is surprising that, until recently, little attention was paid to the advisability of requiring physicians to keep abreast of advances in the field. This is doubly remarkable in that, by conservative estimates, at least ten percent of physicians engage in little or no continuing education.

Not until 1947 did any medical organization become truly concerned about the possible obsolescence of its members as practitioners. That year, the American Academy of General Practice established a rule requiring its members to participate in continuing education to maintain membership in good standing. In this regard, the Academy was far ahead of its time, for not until 1968 did another medical organization follow suit when the Oregon Medical Association amended its bylaws to require continuing education for maintenance of membership. Soon, 17 other states followed Oregon's lead.

Meanwhile, other authorities began to voice their concerns about continuing education. In 1967, a National Commission on Medical Manpower recommended periodic relicensure based on continuing education or on challenge examinations in the physician's specialty. (National Advisory Commission, 1967) In 1971, the Department of Health, Education, and Welfare expressed its concern in a manpower report stating: "The typical state requirements may provide adequate safeguards at the initial entry into a profession. It is a considerably less effective guarantee, however, against the growing problem of obsolescence." (Report on Licensure, 1971) Similarly, John Millis wrote:

> There has been a dramatic change in the period of time which elapses between scientific discovery and its technological application. Through the centuries the time lag has been of the order of a human generation. Today's scientific discovery adds up to the conclusion that knowledge and its consequent skill are subject to rapid obsolescence, that definitions of minimum competence need constant upward revision. (Millis, 1970)

The Secretary's Commission on Medical Malpractice was also a champion of mandatory continuing education, even though it was unable to correlate malpractice actions with failure to obtain continuing education. (Medical Malpractice, 1971) The legislative approach began in 1969 when Kansas enacted a law permitting the Board of the Healing Arts to pass regluations requiring continuing education. However, the law contained a curious provision which forbade implementation without the approval of the majority of members of the Board. Such approval was not forthcoming for eight years.

In 1971, New Mexico became the first state to pass and implement a law linking continuing medical education with re-registration of licenses. The idea was initiated by the Committee on Continuing Education of the State Medical Society, whose members had been concerned over the long existing policy of life-long licensure. While these members approved of the aims of the Oregon Medical Association, they thought that more incentives were necessary because expulsion from the medical society would not interfere with the right to practice. The legislature passed the bill over the objections of many members of the New Mexico Medical Society who loudly voiced their hatred of compulsion, apparently overlooking the fact that compulsion was involved in the original licensure process. Subsequently, 25 other states passed similar laws.

Objections to CE Requirements

There have been other opponents to mandatory continuing education including medical educators, the American Medical Association (AMA) and the American Society of Internal Medicine (ASIM). Their objections are based on various grounds.

Many medical educators maintain that no studies have ever been carried out which prove that participation in continuing education improves patient care or changes habits of practice. Perhaps they are still influenced by Peterson's extensive study of general practitioners in North Carolina, from which he concluded that postgraduate education did not greatly influence medical practice. (Peterson, 1956) In other words, the physicians studied might have known better but they did not apply their knowledge to their practice.

Peterson's report was one of the first efforts to evaluate continuing medical education, and his conclusions were indeed discouraging. Prior to that, the attitude toward the assessment of results of continuing education was that it was an attempt to measure the unmeasurable. However, many physicians, including educators, continued to accept the benefits of continuing education as an article of faith, notwithstanding the mixed empirical evidence.

Meeting These Objections

Beginning in the 1960s, an ever increasing number of reports have appeared in the literature attempting to determine whether or not continuing education improves the practice habits of physicians. As might be expected, many of the results were questionable because of faulty methods of appraisal. In 1977, Bertram and Brooks-Bertram collected an extensive bibliography on the subject; this consisted of a total of 86 references. (Bertram and Brooks-Bertram, 1977) Educational offerings were assessed by a variety of methods, and in many instances the authors proved that continuing education did improve patient care by changing the practice habits of physicians for the better. For example, Rubenstein reported on the Stanford experience. (Rubenstein, 1973) For several reasons, the Stanford School of Medicine has had a cooperative relationship with several community hospitals in providing continuing education. By means of chart audits, the author discovered that there was widespread misuse of blood banks in that the physicians were ordering transfusions of whole blood on a large scale when they should have been using packed red cells. The members of the Stanford Department of Continuing Education then delivered an intensive series of lectures on the proper use of blood and its components. After a suitable length of time, they conducted a second audit which revealed a significant improvement in the use of blood. Furthermore, the improvement in practice held up a year later.

A second example of the benefits of continuing education was reported by Inui in 1973. (Inui, 1973) In the outpatient department of the Johns Hopkins Hospital, the staff conducted a series of tutorials on hypertension. As a result, physician information increased, and physicians allocated more time to patient teaching, with a resulting increase in patient knowledge and compliance with improved blood pressure control.

Although I can point to many other examples of the beneficial effects of continuing education upon physician competence, widespread doubts remain, due mainly to varying methods of evaluation ranging from a true comparison of pre- and post-course behavior to self-evaluation by physicians, which often may be meaningless as it may be based merely on a "happiness index." However, there are by now a sufficient number of reports that prove that continuing education can improve physician performance.

The American Medical Association, while it is in favor of continuing medical education, opposes the mandatory approach.

Yet, it has not faced the problem of life-long licensure and has made no suggestion about how to resolve the problem. Possibly the AMA is satisfied with a status quo that solves neither educational nor political problems.

Many physicians, with an air of triumph, continue to ask such well-worn questions as, "How do you know that doctors do not sign in for courses and immediately head for the golf course?" and "Can you prove that physicians get anything out of continuing education as they might sleep through the lectures?" To the first question, I reply: "In any profession, there are a certain number of cheaters about whom we can do nothing short of herding them into the lecture halls and locking the doors. Certainly, we are not ready to do this. However, from my observations, covering a period of several years, I place the proportion of such cheaters at one percent or less." My answer to the second question is, "Yes, any audience will contain a few sleepy members, some of whom will remain drowsy if the offerings are continually boring." One answer to the problem of somnolence is the presentation of lively lectures by experienced speakers. Another is to vary the methods of presentation of topics, departing as much as possible from stereotyped lectures. Moreover, in view of the investment of time and money required for the updating of knowledge, the somnolent physician is wasting both, to the detriment of himself and his patients. To those who base their objections on hatred of compulsion, I say, society has had only minimal control over the medical profession for all too many years, as evidenced by the system of life-long licensure.

This is the age of the consumer as well as of the litigant. To both of these groups, physicians must offer assurance not only of initial competence but also of continuing competence. Although knowledge is only one component of competence, without it mere technical skill means nothing. Therefore, because of the continuing explosion of medical knowledge, continuing education is essential to continuing competence.

Chapter 8

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Chapter 9

PROFICIENCY TESTING REQUIREMENTS OF THE FEDERAL AVIATION ADMINISTRATION

by

Edgar C. Fell

It is indeed a pleasure for me to be here today to share with you the Federal Aviation Administration's approach toward assuring the continuing competence of flight crewmembers in the air carrier industry. All too often, the general public hears about the FAA following a major catastrophic accident or when your flight attendant wakes you from a sound sleep to tell you that FAA regulations require you to put your seat back in its full upright position for landing. I hope that after my presentation you will have greater insight into how the FAA, in conjunction with the air carrier industry, works to assure your safety as a passenger.

Professionals in Air Transport and Health Care

While your Commission and the FAA are worlds apart with regard to the professions for which we establish standards, we share the same responsibility to that portion of the public that relies on those professions. Whether people are entrusted to the skills of airline pilots or those of professionals in the field of health services, they should expect safety and consideration for their well-being. Indeed, it is with regard to the safety and well-being of the public which we serve that the National Commission for Health Certifying Agencies and the FAA share a common responsibility. The very nature of the industries with which we are associated demands the highest degree of professionalism. The only manner of ensuring that professionalism is to establish high entrance level standards and a means for periodic reevaluation on the basis of those standards.

I am sure that most of you here today traveled by commercial airplane to New Orleans. I am equally sure that you would be appalled if someone were to tell you that the captain of the airplane in which you were riding had not been evaluated for competence since obtaining his original certification as an airline transport pilot some 5, 10 or 15 years ago.

Fortunately, I can tell you that this did not, could not happen. An airline captain's skills and knowledge are assessed, through a program which I shall outline, every six months.

But, if you or I get sick and need an operation, can we be assured that the surgeon holding the scalpel has been reexamined since receiving an initial license? Could we even be assured that this surgeon would have to have performed at least one or two similar operations within a given period of time before performing surgery on one of us? Is there a need to examine, on a continuing basis, the competence of a professional whom a person must rely on for good health? If so, in what way and to what extent?

It is obvious from the theme of this meeting that these are questions which your Commission is confronting. I would like to present for your consideration one method used by the FAA and the airline industry for continually monitoring and evaluating the competence of a professional airline pilot. This assembly may find some of the concepts employed by the FAA useful in the development of your own continuing competence assessment program.

An Example of Crewmember Requirements

Let's start by looking at the typical qualifications of a newly hired airline pilot and follow his career progression until the time he becomes an airline captain. The FAA requires a co-pilot for an airline to hold at least a commercial pilot certificate with an instrument rating and a second-class medical certificate. These are the minimum standards set by the FAA for an airline co-pilot. However, because of the attractiveness that the position of airline pilot holds, the airlines actually are able to set much higher qualification standards in their hiring practices. Today, a newly hired co-pilot typically holds a commercial pilot license, and a first-class medical certificate, has passed the flight engineer and airline transport pilot written examinations, and probably has at least 1,500 hours of pilot time with experience in jet aircraft as well as a college degree. The newly hired airline flight crewmember is already a highly qualified individual.

An individual hired by an airline begins continuous training in the airline's FAA-approved training program. For the purpose of this discussion today, we are going to follow a person who has been assigned duties on a B-727 from initial training until becoming an airline captain.

The first training that this new employee will receive is initial training on the duties and responsibilities as a flight engineer on the B-727. After receiving initial training, the employee is observed in the first 12 hours of operating experience by a company check airman or qualified flight engineer. Thereafter, a flight engineer must log at least 50 hours flight time in the B-727 every six months or, if these hours are not achieved, must take a flight check. Additionally, the flight engineer must take recurrent training every 12 months consisting of 25 hours of ground training and a flight check or a simulator course of training.

Typically, after serving for several years as a flight engineer, a person would be ready to upgrade to the co-pilot position. Before doing this, however, one must undergo another phase of training known as upgrade training. This is training required of a flight crewmember being trained for a new position on the same airplane.

After completing second-in-command upgrade training, the individual must be observed in line operations under the supervision of a check pilot. Therefore, the second-in-commnd will receive recurrent ground training every 12 months along with recurrent flight training, a proficiency check, or a simulator course of training.

Upgrading to Pilot

Having served as second-in-command and after passing the airline transport pilot written examination, obtaining a first-class medical certificate, and logging a minimum of 1,500 hours pilot time, an individual would be ready to begin upgrade training for the airline captain position. A prospective captain must again undergo initial ground training pertaining to the pilot-in-command position. After ground training, one moves onto flight training in the airplane and simulator on FAA-specified maneuvers and procedures. An individual who does not already hold an airline transport pilot certificate (ATPC), he must successfully complete a certification flight check conducted by an FAA inspector. A pilot already holding an ATPC is required to complete a type-rating flight check or, if the pilot already holds an ATPC with a type-rating, a proficiency check.

After training and flight check and before being released to assume the duties of an airline captain, the pilot then must be observed on the line by a check pilot. If any training was conducted in a simulator, one flight leg must be observed by an FAA inspector.

Thereafter, an airline captain must complete recurrent ground trainning and a proficiency check every 12 months. Every six months, one must undergo either a proficiency check or a simulator course of training.

Continual Evaluation

So as you can see, an airline flight crewmember undergoes a continuous evaluation program. This program is in effect throughout one's career and covers each flightcrew position.

* * * *

Although I have not detailed the typical air carrier flightcrew training program, I hope I have provided you with a better insight as to how the FAA has approached the problem of continuing competence assessment of those professionals responsible for your safety during air travel.

Chapter 10

DEVELOPING A RECERTIFICATION EXAMINATION

by

Robert Burmeister

Five years ago, with the support of a $475,000 grant from the W.K. Kellogg Foundation for a project on the Practice, Certification and Education of Long-Term Care Administrators (PCE), the American College of Nursing Home Administrators (ACNHA) and its "sister" organization, the Foundation of ACNHA, Inc., began the "journey"--a rigorous and formidable journey--toward establishing a competency-based certification program for nursing home administrators. This paper briefly describes results from the PCE project with particular emphasis on the development of computer-assisted simulation of nursing home operations for purposes of continuing certification (recertification) of professional competence. In deference to Webster, for purposes of this paper the certification of competence is defined as the assessment of an individual's ability to apply knowledge in a way that produces acceptable solutions to problems. (Senior, 1976)

Defining Competence in Nursing Home Administration

There are presently around 23,000 active, licensed nursing home administrators in the United States. (State Surveys, 1978) Further, it has been estimated that in the current decade the demand for institutional long-term care will increase by around 87.5 percent (from 1.6 million beds in 1975 to 3.0 million beds in 1985). (Long-Term Care, 1977) Still, up until recently, and in spite of the federal government's 1967 mandate requiring licensed administrators for nursing homes participating in Medicare/Medicaid, (State Licensure Requirements, 1979) there have been no serious attempts based upon valid empirical evidence to delineate the nursing home administrator's role for purposes of defining profesional competence. (Allison, 1975) The field of nursing home administration has, in addition but perhaps relatedly, not enjoyed the privileges and benefits related to a recognized professional education program at the university level.

Establishing a Data Base

As part of the PCE project, a national mail survey of nursing home administrators was undertaken in 1976-1977 in order to establish a valid and reliable data base for purposes of developing competency-based certification procedures and a continuing education curriculum.

Over 300 separate items were included on the survey instrument (e.g, biographical histories, training, facility charcteristics) but, for certification purposes, primary interest focused on two separate items intended to delineate nursing home administrator roles: (1) an open-ended survey item requiring respondents to list, in rank order, "important aspects of their job;" and (2) an "inventory of tasks" derived from other studies on health services administration (Khul, 1977) which respondents were required to evaluate in relation to their "involvement," "perceived importance," and "time requirements." The methodology used in coding, scoring, and analysis of the role delineation data is discussed elsewhere. (Burmeister, 1979) The results led to a valid and reliable "definition of professional practice for nursing home administration" describing competencies (i.e., knowledge and abilities) required in the following categories: patient/resident care, personnel relations, management/supervision/community relations, financial management, law/regulation.

Measuring Competence in Nursing Home Administration

Results from an unpublished 1977 survey of selected professions involved in certification indicated that nearly all programs attempted to assess "knowledge, skills, and judgment" (with fewer reporting attempts to assess "attitudes"), usually by multiple-choice examinations. To a lesser extent, essay examinations, evaluation of experience and education, personal references, oral examinations, and simulation/case reports are used. (Burmeister, 1977) Although a variety of certification techniques apparently are used, testing experts assert that the multiple-choice examination is the most efficient and objective approach. (Schoon, 1977) Questions remain, however, as to the relevance and acceptability of such tests as measures of "real-life" situations. (Senior, 1976 and Anastasi, 1977) Assessment of experienced professionals is also an unsolved problem.

In recognition that competence in nursing home administration requires situational knowledge and abilities, two separate assessment techniques were developed: (1) a norm-referenced multiple-choice examination suitable for assessing competencies expected of a licensed nursing home administrator with at least two years of experience; and (2) a computer simulation of nursing home operations with self- and peer-ratings suitable for assessing the competencies expected of a licensed nursing home administrator with four or more years of experience.

Some of the basic operations of the simulation, for purposes of continuing competency assessment, can be described. Participants (up to 50) register for a workshop and form 3-4 member "teams" which will be responsible for managing a 150-bed, proprietary, skilled nursing home for a simulated two-year period. Overall team performance depends on reaching consensus on the facility's philosophies and goals in order to make a series of 30 unique decisions required for each of eight simulated fiscal quarters. Facility performance measures for each of the quarters are reflected in on-site, computer-generated quarterly reports.

Upon completion of the simulation (which requires 14 contact hours), peer-and self-ratings are used to evaluate each individual in relation to demonstrated judgment/decision-making, leadership, and administrative philosophies in the management of the simulated nursing home. Further, based on individual performance on the simulation including results of peer/self ratings, each individual completes a "professional development plan" describing specific activities they intend to pursue in order to fulfill requirements for continuing professional certification (recertification).

While additional pilot tests will be required to establish the validity and reliability of competency measures through the simulation, limited experience to date indicates: (1) that it may be feasible to establish "minimum standards" for team performance in relation to the simulated facility reports (e.g., quality of care, turnover, cost, etc.), and (2) consistent and general agreement between self/peer ratings for individual abilities related to judgment, leadership, and administrative philosophies. By comparison with other ACNHA continuing education offerings, the simulation workshop rates most favorably on the basis of identical participator evaluation forms.

The Politics of Certification of Competency

In May 1979, ACNHA's membership overwhelmingly adopted a resolution recommended by the governing board for the implementation of a professional certification program for nursing home administration. Allowing for time to effect needed bylaw change, it is expected that the program will be operational soon after the College's May 1980 annual meeting.

Owing to the individual state licensure programs and the existence of two separate state licensure examinations (those composed by the National Association of Boards of Examiners for Nursing Home Administrators and the Professional Examination Service), the national certification program--which also will be available for non-members of ACNHA--is expected to facilitate licensure receprocity which has been a serious problem in nursing home administration. Additionally, in relation to professional education, informal discussions have already been initiated with several accredited university programs in health services administration for the purpose of allowing certificants to waive certain traditional academic credentialing towards degree requirements. Recognizing the need for the professionals' support for the program, they have been involved in the development of the program from its inception. Over the last several years, it is estimated that nearly 10,000 administrators have participated--as survey respondents, workshop participants, test item writers, consultants, and committee members--in the development of the program.

It has been a rigorous and formidable "journey," and there is still some distance to travel. But already--in relation to the potential for licensure reciprocity, opportunities to facilitate non-traditional academic credentialing for professional education, and the professions' support for the program they have helped to develop--it appears that the "journey" has made an important difference.

Chapter 10

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Chapter 11

SELF-ASSESSMENT BY PROFESSIONALS

by

Ayres D'Costa

Background

Nicholas Butler is credited with the formulation of the somewhat paradoxical statement that an expert is "one who knows more and more about less and less." Although this definition often is explained as a reflection of specialization, another explanation is in order. A true expert readily acknowledges his or her limitations and often says, "I don't know," instead of bungling through. As the English poet Tennyson wrote: "There lives more faith in honest doubt, believe me, than in half the creeds." The learned person, according to the Greeks, is one engaged in self-understanding. A credible index of vocational or career maturity, according to Super and Crites (1952), is the extent to which one has developed a realistic self-concept.

Within these contexts, self-assessment becomes a cogent goal of health professionals. Hess and Morreau (1976) translate self-assessment as the "voluntary measurement of one's knowledge, skills, or attitudes in a given area." Self-assessment programs are now common for continuing education in medicine (AMA, 1974), and, as Neu and Howrey (1975) concluded after a nationally videotaped administration of their Antibiotic Therapy Test, a self-assessment test can be an effective mechanism for the continuing education of physicians.

Self-assessment approaches to competence assurance have several innate advantages. The professional can identify his or her strengths and weaknesses without risking exposure and humiliation. The professionals then can seek out remedial programs, make up deficiencies, or add to existing strengths. The possibility for conducting a self-assessment program independently also provides the convenience of working at one's own time, place, and pleasure--features that often make the critical difference for busy professionals between keeping up and letting skills slip away.

The Problem

There are concerns that self-assessments may be biased and unreliable. Recent studies of psychology students by Schranger and Terbovic (1976) and by Warren (1976) indicate that measures of self-esteem reflected differences in self-perceptions of competence when no differences in actual competence were present. Likewise, Weinstein, et al., (1975) found that dental students were significantly less critical in their self-evaluations than their clinical faculty. It appears likely that such discrepancies are due to the global nature of the clinical performance assessments (Hammond and Kern, 1959; and Bailit, et al., 1974). There is also a critical difference between student self-evaluation and professional self-assessment that depends on the perceptions of purposes of the assessment.

Serious concerns also have been voiced about the relevance of currently available self-assessment devices and continuing medical education programs in terms of the professional practice needs of physicians. Miller (1967) criticized continuing medical education for using ineffective methods and for focusing on recent breakthroughs in biomedical research rather than on patient care-related needs. Libby, et al., (1975) expressed deep concern with mandatory continuing education programs: "Adults may be coerced into attendance," they said, "but learning and the subsequent application of knowledge may not be forced." In proposing a "process model" for continuing education, Miller (1967) recommended that the adult learner be involved in identifying his or her educational deficits, in examining what he or she does in professional practice, and thereby in establishing realistic priorities for his or her own education.

The Research Hypothesis

This paper presents a self-assessment model that was designed to be relevant to self-ascertained educational deficits, to actual needs of professional practice, and to expressed professional interests. It is hypothesized that continuing professional competence will result if self-assessment is based on a combined analysis of practice requirements, individually felt needs, and educational deficits identified by competence-based examination scores.

The Study

This three-pronged model of self-assessment was implemented by the American Academy of Physician Assistants with the help of a recent contract from the Division of Allied Health Programs in the federal Health Resources Administration (Fisher and D'Costa, 1979). With a role delineation study as the basis, an attempt was made to define the critical functions of a minimally competent physician assistant in terms of test scales selected for their utility in providing feedback for continuing education purposes. A modified version of the critical incident technique (Flanagan, 1954) was utilized to identify scenarios from which test items were then developed. A six-hour self-assessment examination was developed using standard techniques for constructing criterion-referenced tests.

This self-assessment examination has been pilot-tested on a national sample of 110 practicing physician assistants. Along with the 312 professional competence test items that elicit patient management skills with selected multiple-choice item styles, the self-assessment instrument included questions related to practice characteristics and individual professional interests. Feedback on all three domains was coordinated into a single competence model for physician assistants. The entire report is computer generated and consists of four pages of summarized feedback. A separate eight-page interpretive leaflet accompanies the report and serves to explain the data presented to the physician assistant.

Next Steps and Limitations of Study

Research analyses currently are underway to test the associations existing among the three major dimensions of this self-assessment model: competence examination scores, practice characteristics, and individual professional interests. Research questions that are being investigated are: Are physician assistants interested in professional competence areas that relate to their clinical practice? Are competence scores related to practice characteristics? Is interest related to measured competence?

The data base for these investigations is limited to the 110 physician assistants who participated in the pilot test. Although the original sample of 244 was randomly selected to represent the profession, the available sample of responders necessarily is vulnerable to selection bias, although it still appears to be reasonably representative to the profession. An additional limitation is the experimental nature of the test items which have only undergone two try-outs. No scale validation, other than content validity based on expert professional judges, has been established.

Chapter 11

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Chapter 12

AUDIT AS A METHODOLOGY

by

Geraldine L. Ellis

One area of activity that may hold considerable promise in assessing continuing competence is the auditing of professional practice. In the 1970s, the practice audit became the focus of great interest as the result of both private and public initiatives. In the private sector, the Joint Commission on Accreditation of Hospitals (JCAH) has begun to see the potential of practice auditing in increasing institutional accountability. In the public sector, congressional enactment of the PSRO Amendment in 1972, as part of Public Law 92-603, authorized the creation of Professional Standards Review Organizations as a vehicle for monitoring the quality and costs of services financed through federal programs, most notably Medicare and Medicaid. Let us consider the scope of federally mandated audit activity to see whether it may be useful to voluntary efforts at continuing competence assessment.

The Nature of PSRO Review

The legislative mandate requires that local PSROs, formed and administered by physicians in designated areas, review health care services that are provided to patients whose care was paid for largely through Medicare and Medicaid and the Maternal and Child Health and Crippled Children's Programs. PSROs are intended to assure that such care is (a) medically necessary, (b) provided in the appropriate setting, and (c) of acceptable quality. The review system contains three related components: concurrent review (occurring while the patient receives care); retrospective review conducted through either medical care evaluation (MCE) studies or audits; and profile generation from both concurrent and retrospective review data and analysis. Profiles are snapshots of data that show how a particular provider's performance over time compares with established standards and aggregate norms.

Particular aspects of the implementation of the PSRO program may be instructive in suggesting the relevance of practice audits to your Commission's continuing competence assurance efforts. Whereas PSRO review initially focused on physician services rendered to inpatients, review has since been expanded into other settings and been broadened to cover other categories of practitioners. Also of interest is the use of remedial measures. In fact, one feature of the 1972 legislation was the charge that deficiencies in health care services should be corrected by educational and/or administrative means. This latter feature is highly relevant to continuing education and other methods of continuing competence assurance.

So far, PSROs have been established in 191 of the 195 designated areas, and 187 are functioning. Review is conducted either by delegated hospitals or, in non-delegated hospitals, by PSRO staff. In addition, about 50 PSROs review care delivered in long-term care facilities.

Basically, the audit is designed as a problem-solving technique. Its use includes the following elements:

- Problem or potential problem identification;
- Data gathering and peer analysis;
- Intervention for problem resolution;
- Follow-up mechanism to assure the problem was resolved or reduced;
- Documentation and reporting of the study process and outcomes.

Another feature of the audit process is the use of explicit criteria on which the performance of a given practitioner or group of practitioners can be measured. Criteria are defined as predetermined elements of health care, developed by health professionals relying on professional expertise, prior experience, and the scholarly literature, with which aspects of the quality, necessity, and appropriateness of a health care service may be compared. Standards and norms are applied to these criteria.

PSROs and Continuing Competence

For purposes of your charge in continuing competence assurance, I find it necessary to distinguish between audits that specifically assess the performance of individual practitioners and those that assess the performance of a group of practitioners. The audits performed in fulfillment of JCAH and PSRO quality review requirements have focused mostly on care provided by a group of practitioners to a specific group of patients. Of course, this makes it more difficult to identify individual practitioners whose practice has varied from the criteria, but such identification can be and is being done. To illustrate, two medical specialty boards--the

American Board of Family Practice and the American Board of Obstetrics and Gynecology--use audit as one component of their recertification programs. Outside of medicine, an American Occupational Therapy Association study has concluded that audit can be a useful self-assessment tool for that profession.

Audits offer two-fold educational benefits. First, practitioners participating in the development of criteria and in the audit process find this a valuable personal learning experience. Thus, continuing medical education (CME) credit is given for participation in audits. The maximum amount of CME credit that may be earned through participation in PSRO activity varies from state to state, with 60 percent of the total required hours of CME comprising the current highest limit. I would urge all health professions and responsible continuing education accrediting authorities to investigate the possibility of credit for PSRO work.

Secondly, the practitioner whose practice is audited and found to be substandard, or not in tune with currently recognized technology, derives an educational benefit when he or she receives an assessment from peers. Indeed, the assessment frequently triggers educational activity, such as individual counseling under PSRO auspices or a continuing education program provided either at the hospital staff level or through a professional association, when PSROs uncover an educational need on the part of a practitioner population. In any case, feedback in the form of results of the PSRO assessment should direct the practitioner to the area of continuing education that is indicated. Of course, follow-up evaluation is necessary to assure that the corrective action has influenced the practitioner's practice.

I detect a rather general consensus that audit alone cannot resolve the issue of how to assure continued competence. But, I submit that it can play a very important role in the process.

The Flexibility of PSROs

Today, change is taking place in peer review. JCAH recently relaxed its quality assurance standard for hospitals and no longer requires as many audits as it has in the past. Similarly, we in the PSRO program have become aware that the predominant concern of PSROs has been to comply with our requirement that a certain number of MCE studies be performed in each designated area. Thus, PSROs tended not to focus on problem identification and problem reduction or resolution.

In collaboration with JCAH, we consequently have rephrased our quality review policy to place emphasis on problem identification and reduction or resolution. We are asking PSROs to implement the policy on a trial basis in 1980 and intend to finalize the policy by January 1981. This revised policy does not negate the audit process as a quality review methodology. Like JCAH, we view it as a viable method that will be used by both hospitals and PSROs to assess quality of care.

Collaboration between the PSRO program and JCHA reflects the similarity in our approaches to peer review. The attached chart depicts the common activities and different inplementation methods of the publicity mandated PSRO and privately mandated JCAH programs.

I hope that those of you who typically practice outside the hospital setting will discover useful ways of applying the audit process in assessing practice. Because the audit process involves generalizable functions, such measuring records, reports, and other forms of data against criteria and standards of performance, the process can be used in many settings, including offices, home facilities, and laboratories.

In closing, let me emphasize the versatility of the practice audit as a tool for assessing quality, for assuring quality, for enhancing our learning, and for demonstrating that we in the health care sector take our obligation of accountability seriously. It is not the be-all or the end-all of assuring continuing competence, but it can and reasonably should be a vital and significant part of the total effort.

PSRO - JCAH
Quality Review Policy

PSRO	JCAH
o Accountability - PSRO	o Accountability - Hospital Board
o Integration and Coordination — PSRO and Hospital Quality Assurance Board	o Integration and Coordination - medical staff - administration - professional departments - hospital committees
o PSRO problems identified - prioritized PSRO, Hospitals and National data - national PSRO program goals - PSRO objectives - PSRO problem list	o Problems identified and priorities - hospital data - PSRO data - other data
o Studies performed - areawide - subareawide - delegated hospitals (4) - non-delegated hospitals (4) - criteria established - physician involvement - encourages multidisciplinary studies	o Studies performed - no number requirement - criteria established
o Study results analyzed	o Study results analyzed - requires multidisciplinary studies
o Intervention	o Intervention
o Resolution	o Resolution
o Follow-up	o Follow-up
o Impact	o Impact
o Documentation	o Documentation

PART TWO

DIRECTIONS FOR CHANGE

Chapter 13

Overview: Observations on Program Development

by

Peggy McCarberg

The currently rapid pace of technological advances leads to recognition today that entry-level skills for any given profession do not last forever. One educator borrows a term from nuclear physics to describe this phenomenon:

> The half-life of a professional's competence can be described as the time after completion of professional training when, because of new developments, practicing professionals have become roughly half as competent as they were upon graduation to meet the demands of their profession.

Based on this definition, the half-life of medical knowledge recently has been estimated to be five years. (Dubin, 1972)

The prospect of skills and knowledge becoming obsolescent in only a few years indicates the importance of problems in continuing competence. A health professional cannot provide safe, high-quality service throughout his or her career by relying solely on initial entry knowledge. There are simply too many new developments in the medical field that demand attention.

Professionals can be expected to recognize a duty to is patients and to their profession to strive for at least a minimal degree of proficiency in new techniques. But, is this what continuing competency is all about: a fortuitious accumulation of skills acquired expediently by too few practitioners? It need not be.

The Role of Professional Associations

Professional associations, whether or not they play a supportive role in certification programs, increasingly have shown leadership in continuing competence. In particular, associations are grappling with the problem that certificates awarded to members lose value over the years as a reliable indicator of ability if they are not updated periodically. (Hanavan, 1979)

An added benefit will be realized by the health care system generally as a result of involvement of national associations in the continuing competence issue. Regional, state, or local requirements for health professionals are appropriate in some situations but not where they serve to hamper unduly the mobility of health professionals. Shortages of available health services can be exacerbated by the imposition of local customs of pracitioners. Nationwide, uniform re-certification standards can further the goal of an improved health care system and increase the mobility of professionals. (Cohen, 1979)

Role Definition

To avoid a haphazard, inefficient approach, there are several steps a professional or certifying organization should take in developing a mechanism to assess continuing competence. Initially, it is necessary to make a detailed analysis of the profession. What precisely is required of a competent practitioner? It is imperative to ascertain what is demanded of the professional before it can be discovered what is needed to keep him or her current.

Work settings will also have an impact on continued competence. A program must ultimately be flexible enough to adapt to the varied work settings of the professional. For example, a pharmacist dispensing drugs in a hospital uses skills and techniques which differ somewhat from those utilized by a pharmacist managing a corner drug store.

When basic skills and job requirments are delineated, a definition of continuing competence relevant to the particular profession needs to be developed. Will it refer to skills equivalent to those a new graduate possesses, or should continued competence move beyond this level and indicate a greater degree of expertise? Or, finally, should it be narrowly defined and focus on specific problem-solving? (Burg, 1979) Continuing competence can refer to any or all of these concepts, depending on the needs of professionals, imperatives of health care policy and employment or reimbursement systems, and the nature of the profession. What is critical is that the definition is structured to encompass those goals practitioners should reasonably intend to achieve through renewed learning.

It is impossible to over-emphasize the role of the individual in both program development and quality health delivery. The two are inextricably intertwined. Advanced medical techniques are useless and even dangerous if used carelessly or inappropriately by the individual. Costly errors can be avoided only by competent personnel, and the potential risk to patients can be lessened by a professional's participation in relevant competence programs.

In exercising a leadership role, professional associations or certifying agencies wisely seek input from members and anticipate program participations. Individuals are resistant to change and may reject even well-planned programs if their views are ignored. (Hoffman, 1979) Organizations early on can ask participants to identify the needs and program expectations and incorporate those ideas to whatever extent is possible. To succeed, programs must prove acceptable to the profession.

Goal Identification

As far as professionals' determination of their own goals is concerned, there is some question as to whether one can reliably perceive one's own weakness. Yet, a supervisor or peer's observations of another's needs may also prove inaccurate. The discrepancy was revealed in a study focusing on hospital-employed registered nurses. (Chatham, 1979) It was hypothesized that when asked to rate educational priorities for registered nurses (RNs), directors of nursing would respond in a manner different from staff RNs. The hypothesis was verified: Programs based on facts and didactic material relevant to actual tasks performed by a staff worker were rated highly by the staff RNs. Conversely, nursing directors favored programs emphasizing how goals are to be achieved and the flow of ideas.

The underlying reasons for the actual choices made by the nurses remain unknown, but the discrepancy evinces a need for input from both groups. Even if the nursing directors' perceptions were correct, that would not be sufficient information for establishing educational goals, because learning cannot be forced on an unwilling student but rather is accepted when it is perceived to be relevant to one's needs. (Larocco and Polit, 1978) Should the director's observations prove correct, the staff workers may need to become convinced of that fact in order to benefit from a program based on those observations. This conflict of perceived needs further reflects the fact that support of employers and supervisors is critical in order for a continuing competence program to succeed.

Although the cost involved for participants in advanced learning programs is frequently cited as a formidable obstacle, recent studies indicate that it is less influential than had been believed (Seymour, 1979 and Smorynski, 1979), with time constraints cited more often as a reason for nonparticipation in continuing education programs. Conflicting work schedules and home demands were indicated by health care workers as barriers to continuing education. Adjustment of work hours by employees could increase the level of participation. Although both patients and employers would suffer a loss due to a health care worker's absence, increasing one's knowledge through a suitable course or conference should prove beneficial to all in the long run.

Choosing a Program

Once needs have been assessed, the means appropriate for achieving goals must be determined. Health care is a combination of talent, clinical judgment, skills, and knowledge. All aspects of health care delivery need periodic updating, so that a variety of programs is necessary in order to meet these needs. Seminars, conferences, self-assessment tests, didactic lectures, group discussions, demonstrations, proficiency trials, and academic courses are all possible methods. Flexibility and imagination can be used to help create innovative programs appropriate to individual needs.

Historically, continuing education has been relied on by professionals to keep abreast of new developments in their field. There is, however, a growing trend toward self-assessment as a viable means of professional growth. With cost and time constraints impinging on traditionally rigid programming, self-assessment proves very convenient. The individual can work at updating knowledge whenever his or her schedule permits.

This is not to suggest that self-assessment becomes the sole or even predominant means of achieving continued competence. It is important that program planners remain open to suggestions and change. Attempting to identify the one program method which will serve all the needs of a professional may prove futile. A pluralistic approach integrating various components of competence may prove more realistic over time.

In recognition of the fact that health care workers do not function in isolation, there has been some demand for multi-disciplinary programs. (Bloom, 1977) The cost of establishing programs remains critical, and avoiding duplication of services is a factor to be considered. One way to minimize costs is through a single presentation which would be of interest to more than one profession. However, educators may hesitate to combine disciplines due to potential interdisciplinary friction and insecurities, knowledge bases that are perceived as inadequate, and insufficient time alloted to create meaningful interdisciplinary learning experiences. (Weaver, 1979) These problems may eventually defeat a program, but should not totally inhibit attempts at overcoming them, especially given the importance of interdisciplinary relationships to patient care. Again, flexibility and innovation should be the guiding principles in creating continuing competence programs.

Whenever education for professionals is discussed, the issue of mandatory requirements is raised. Compelling arguments are made for both voluntary and mandatory programs. An early solution to the dilemma is not foreseen. For the time being, what is essential is establishment of a program that works. Besides the salutary direct effect on health care, demonstration of responsibility by professionals themselves, through either successful voluntary or mandatory programs for keeping current, can restrain undue government intervention. However, prudence should be exercised to ensure that wasteful, ineffectual plans are not hastily enacted to prevent anticipated interference by the government. Such a reaction will benefit no one but would rather demonstrate the profession's inability to cope with the imperative of continuing competence.

Chapter 13

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Chapter 14

ASSURING THE CONTINUED COMPETENCE OF MEDICAL TECHNOLOGISTS

by

Diana Mass

An illustrative experience in the establishment by a professional association of a mechanism to assure continuing competence may be the current effort of the American Society for Medical Technology (ASMT). The Society represents more than 23,000 health care professionals engaged in the delivery of clinical laboratory services. The ASMT membership represents a diversity of non-physician specialists and generalists within the clinical laboratory sciences.

ASMT has as one of its primary goals a Quality Assurance Program with four major aspects: competence of personnel; quality of material (methods, reagents, and instruments); internal quality control; and reliable reporting systems. Although all of these factors are essential to quality assurance, quality begins with the individuals providing the service. Therefore, the most important aspect, in ASMT's view, is competence of personnel.

The centerpiece of the Quality Assurance Program is in fact a Competence Assurance System, devised to (1) define competence, (2) provide the opportunities for laboratory professionals to achieve competence, and (3) monitor the relevance of the formal mechanism that actually measures achievement of competence.

Components of the Competence Assurance System

The first component, defining competence, is a major hurdle, or series of hurdles, in the development of the Competence Assurance System. The general ASMT strategy is to define competence by delineating the roles, or levels of practice, of clinical laboratory professionals (technicians, technologists, and specialists) in terms of specific knowledge, skills, and attitudes required for acceptable performance. By examining the practice of clinical laboratory science, ASMT has collected data about which functions are performed, what functions are likely to be performed in the future, what knowledge is needed for performance, and what abilities are similarly required.

The second component or objective is to provide opportunities for achievement of competence. In this area, ASMT is acting to develop education and self-assessment mechanisms that are commensurate with explicitly defined levels of practice. These educational mechanisms should enable a professional to maintain a current level of responsibility, move to another level, or progress to an expanded role. ASMT currently is developing performance objectives in order to establish competence-based educational mechanisms. It is anticipated that these mechanisms will facilitate the development of competence needed in the various levels of responsibility.

ASMT's primary concern in achieving the third objective, that of monitoring, is that the evaluation mechanism actually measure the competencies that ASMT has defined. Although ASMT will provide the current data for monitoring and updating the formal competence mechanisms, the Society supports the concept of an autonomous certification process.

In real-life terms, the idea of the Competence Assurance System is that the laboratory professional will participate in the system to ascertain competence at an identified level of practice. The professional will participate in an educational program containing a self-assessment component to facilitate the identification of existing deficiencies. The results of this assessment will become the basis for determining the type and content of continuing education programs. This entire process will better prepare the professional to demonstrate competence to a certification agency for recertification purposes, to an employer for performance evaluation purposes, or simply to the individual as a professional.

Major Points of Decision

The Society encountered several key decision points in framing the system. The first major decision, not surprisingly, was to undertake a monumental and far-reaching program now called the Competence Assurance System. This decision was predicated on the philosophy that it is the profession's responsibility to define the scope and levels of function of its members. ASMT perceived a need to define this: (1) for the profession (2) for the certification agencies, in order to avoid confusion about who should be certified to do what; (3) to the public and consumers to educate them regarding clinical laboratory service; and (4) to the government.

The second major decision was to base the system on job function. Competence is inextricably bound to the specific functions performed. Because job function is the crux of the whole system, it needed to be defined realistically and practically.

Historically, the "job" of technologists and others has been defined by the subject matter taught in schools or by the content of credentialing examinations, but the history is not fully satisfying. The Society decided to define the job function by looking toward the primary source of information, namely the job itself. Although the concept of analyzing the job in order to define it has logical appeal, it is difficult to implement because of the shortage of documentation of what the job is at the job site.

Although ASMT decided to define job functions by investigating job practices, it elected not to conduct a classical job analysis, because a classical analysis often reflects institutional idiosyncrasies rather than universal trends. Also, a job analysis would identify only what is being done in laboratories today, not what should be done. So, task forces were assembled to develop definitions of the job.

Other decisions involved going to the membership for validation of the philosophy of the system in its early stages. For example, a statement of philosophy was adopted by the ASMT house of delegates in 1979 and now serves as the framework for the system. Among other points, this statement of philosophy asserts that, because some learning takes place outside the academic environment, standards and mechanisms to equate experience and training with formal education should be an integral part of the system. The statement goes on to postulate the need for formal evaluation to determine if a particular set of years and types of experience and/or training leads to the development of competence equivalent to that achieved through academic education.

At various points, it was decided to seek input from both academic programs and the practice world in developing definitions and objectives. Thus, standards of practice are being developed from data derived from clinical as well as academic evaluation criteria. Ultimately, these standards of practice are intended to be keyed to specific practice levels.

Obstacles Faced

Marshalling of adequate resources comprises the major source of difficulty in developing the Competence Assurance System. Not only is an enormous amount of money needed to develop and implement a system, but also there is a problem in finding and recruiting individuals who have the time to work on the various projects. The extensive use of task forces in developing the system renders the entire structure dependent on volunteerism. However, the use of volunteers is absolutely necessary to gain the broad-based consensus needed for acceptance by the profession.

An ongoing concern is the necessity to communicate with the profession at large and others about the system in order to avoid the mis-perception that the system will have a negative impact on current employment. Close communication between the council responsible for developing the system and the ASMT board of directors has minimized the extent of any communication problems.

Several tasks remain to be accomplished and each presents its own difficulties. An oversight task force has been appointed to analyze work to date, and identify areas and activities that need further work and development. Another area to be addressed is the cost-effectiveness of the system. This presents some difficulty, in that adequate assessment criteria have not yet been developed. Nevertheless, these criteria must be established because of the potential impact of any costs with respect to the health care delivery system.

Development of educational resources will be both a product and a part of the system. ASMT currently is performing a needs analysis to determine which educational materials are needed by laboratory professionals to maintain competence in the expanding field of clinical laboratory science. A resource center also will be needed to supply individuals with segments of learning materials including a self-assessment component.

In short, the effort is equal to the challenge, and the challenge is quality in health care. Underlying ASMT's expectations for its Competence Assurance System are the accountability of individuals for their own actions and of the profession for the performance of its members. The system is intended to provide laboratory professionals the opportunity to become everything that they are capable of becoming.

Chapter 15

PROFESSIONAL COMPETENCE AND THE PHARMACIST

by

Samuel H. Kalman*

Michigan's 1978 legislative initiative, requiring the assessment by 1984 of "...the continued competence of licensees as a condition of periodic license renewal," (Michigan Public Acts) reflected growing public concern about the continuing competence of health care professionals and the public's desire to act to assure continuing competence. The profession of pharmacy, accepting and perhaps sharing such concern and desire, has used the Michigan statute as a catalyst for action effectively promoting competence-based practitioner evaluation.

Early Recognition of the Need for a Continuing Competence Program

Within pharmacy, the importance of professionals' maintaining practice competence has long been recognized. In 1949, the General Report of the Pharmaceutical Survey (known popularly as the Elliott Report), in addressing the issue of "inservice training for pharmacists," stated that the continuous changes taking place and the character, number, and form of medicinal substances have placed upon the competent pharmacist the obligation of continuing serious professional study. Over the years, much consideration has been given to issues of competence in conferences and papers discussing both the initial preparation and continuing education of pharmacists (Proceedings, Conference on Health Education, 1967; Proceedings, Conference on Pharmacy Manpower, 1970; Houle, 1974; Rosinski, 1973).

In 1972, capping many years of debate, the House of Delegates of the American Pharmaceutical Association (APhA) adopted a resolution mandating the development of "techniques and methodologies that could be used in ensuring the continued competency of pharmacy practitioners." The following year, APhA and the American Association of Colleges of Pharmacy formed a joint Task Force on Continuing Competency in Pharmacy, which was charged "to prepare a statement of basic principles and policies with respect to the continuing competence of pharmacists." These actions placed in motion a train of events which firmly set the direction for the work in competency subsequently undertaken by the profession.

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The joint Task Force reported in 1974. It recommended that the profession establish standards for the continuing competence of pharmacists. (Final Report, AACP/APhA Task Force, 1975) Responding to this recommendation, the two associations contracted with the Educational Testing Service in 1976 to conduct an analysis of the practice of pharmacy. The task analysis and the subsequent nationwide survey of practitioners resulted in the identification and verification of 69 basic responsibilities of pharmacists. (National Study of the Practice of Pharmacy, 1978) The list of these responsibilities, along with the associated tasks and sub-tasks with which the responsibilities may be fulfilled, was published in the March, 1979 issue of American Pharmacy as "Standards of Practice for the Profession of Pharmacy."

The standards provided a generic definition of the contemporary practice of pharmacy. By describing what pharmacists do, the standards provide a foundation for work in competence assessment and professional development. Pharmacists for the Future, the 1975 report of a study commission chaired by John Millis, added credence to the basic premise of the need for a competence-based system: "The objective of pharmacy education is to prepare students to practice. It is not sufficient to educate them only to know; they must also be trained to do..." (Study Commission on Pharmacy, 1975).

Competence and Education

This distinction between knowing and doing is at the heart of the continuing competence/continuing education debate. Although no assessment is content-free, the content should be related to the responsibilities of the individual whose competence is being tested. It is also imperative that the content be presented in a way that the individual is allowed to demonstrate his or her ability to apply it in practice, by showing what would be done in appropriate practice situations. Reliance on knowledge measures as the sole indicators of competence misses the mark completely, because the capacity to act requires not only knowledge but also a set of abilities that allows the pharmacist to apply knowledge and skills in everyday practice situations.

To date, the competence of pharmacists, like that of other health care professionals, has been "assured" by selecting intellectually capable students, educating and training them in the basic pharmaceutical sciences, examining them, and, if they "pass," licensing them to practice. The concern today, reflected in the Michigan law, is that the educational process and a one-time test of competence at the beginning of the practitioner's career is not enough to assure competence throughout the career.

The question is, can it be assumed that a health care professional voluntarily will keep up with advances in the field and continue to grow professionally? The public, in increasing numbers, questions this assumption. Concern over the possible deterioration of competence over time has resulted in the Michigan decision to examine periodically the continued competence of the professional. The pharmacy profession's approach is to develop a voluntary system that enables the pharmacist to maintain competence. This approach goes significantly beyond the exclusive dependence on test grades or the accumulation of continued education credits.

Rationale for Change

Why must such a system be developed?

o No one has been able to demonstrate the capacity of paper-and-pencil tests of knowledge to predict competence to practice (Richards, 1976).

o Merely measuring competence with a test score provides no means for professional development or for remedying identified deficiencies.

o The real-world practice of pharmacy is not "served up" as a set of academic concepts and facts to master, but rather requires skills that currently are not being measured.

o The assessment of practice competence should have as its focal point the pharmacist's actual practice setting, entailing duties, responsibilities, and tasks that the pharmacist performs every day.

Current work in competency assessment and development in pharmacy is premised on the assumption that, given the opportunity and the means for self-assessment and development, the pharmacist will respond by periodically assessing himself, and follow up this self-assessment by developing strategies for not only the maintenance of a minimal level of competence, but also for the development of higher levels of competence to practice.

How can the pharmacist demonstrate that he is capable of performing required functions competently?

Based on the findings in this area of research, the following conclusions concerning the practice of pharmacy and methods for assessing the competence of the pharmacist have been reached:

o Pharmacists' responsibilities extend beyond the mere dispensing of drug products. Pharmacists have a definite role in providing information and monitoring services to the patient and members of the health care team (including the physician) in order to optimize the therapeutic process.

o The role of the competent pharmacist cannot be defined solely in terms of knowledge areas to be mastered. Many skills--interpersonal, communicative, analytical, decision-making--are required to define competency.

o Pharmacists are engaged in a series of interrelated and interdependent tasks (a practice process) in delivering pharmacy products and services.

o Although each pharmacist is involved in a practice process, no two pharmacists experience the process in exactly the same fashion. Each pharmacist brings a unique set of skills, abilities, and knowledge that he applies in a unique way to a unique set of practice demands. Assessment devices to measure competency, therefore, must be sensitive to allow for variability among pharmacists and practice settings.

o The central activities of the pharmacist are fulfilled at crucial practice interfaces where the pharmacist receives, analyzes and imparts specialized information and services. These interfaces include, for example, the pharmacist and the patient, the pharmacist and the physician, the pharmacist and the nurse, the pharmacist and other pharmacists, and the pharmacist and the wholesalers.

o The knowledge and skills required by the competent pharmacist should be defined jointly by practicing pharmacists and subject matter experts.

o All assessment and development material should be based squarely on how pharmacists use knowledge in their practice, rather than being tied only to what the pharmacist is expected to know.

o All assessment and development material should be based squarely on how pharmacists use knowledge in their practice, rather than being tied only to what the pharmacist is expected to know.

o The assessment and development effort must be individualized so that the pharmacist is not expected to demonstrate competency in areas for which he does not have responsibility.

o Assessment should be as realistic and meaningful as possible in keeping with the actual situations encountered in the work environment.

o Pharmacists should have the means and the opportunity to continue their education outside the formal learning process.

o Self-assessment material should be confidential and non-threatening, yet challenging and rigorous to provide the pharmacist with a reliable reading of his competence to practice.

o The pharmacist, as a professional, must take control of his own assessment and development of competence.

Maintaining competence, therefore, requires assessment of individual professional activities. It logically follows that deficiencies, if there are any, call for remedial action to be taken on the part of the concerned practitioner. As mentioned above, the profession advocates that pharmacists assume a larger responsibility for their own competence. This means that pharmacists must be able to evaluate their present practice proficiency to determine how they "measure up."

At the same time it is recognized that this kind of professional scrutiny requires techniques and skills that are not generally part of the pharmacist's expertise.

Because of the present emphasis on assuring professional competence, there is a need to develop more "formal" mechanisms by which professionals may assess their competence, and if found lacking, know how and be able to obtain appropriate learning resources to fill in the "gaps," or to add new competencies. APhA recognizes this need for a more structured assessment process and has been working toward developing a Professional Assessment and Development Program. A pilot program to test and experiment with some practical approaches is now under way.

The pilot program is the APhA/Michigan Pharmacists Association Collaborative Study in Competency Assessment, which is being conducted in the state of Michigan. The joint effort provides an opportunity for the mutual interests of both associations to be addressed simultaneously: the need to research workable mechanisms by which the pharmacist may realistically assess his or her own competence to practice. (Competency Assurance System in Cambridge, Massachusetts is the contractor.)

Materials developed for the pilot program take into consideration five "indicators" of competence, based on research of the literature dealing with competency assessment and on observations of pharmacy practice. In the pilot study these five indicators are interwoven throughout the program:

- Level of mastery of the body of knowledge that supports the individual's practice of pharmacy;
- Proficiency in the application of the appropriate skills, both process and psychomotor;
- Understanding of the overall process of the practice of pharmacy and the specific task requirements to fulfill responsibilities imposed by the practice;
- Level of experience of the pharmacist and the pharmacist's individual characteristics (motivations);
- Observable behavior, that is, the actual task performance exhibited when the pharmacist interacts with other members of the health care team, patients, industry representatives, other pharmacists, pharmacy personnel, and the business community.

The major goal of the APhA/MPA Collaborative Study in Competence Assessment is to develop a prototype of a system for assessing the individual's competency to practice pharmacy. In developing this prototype, the utilization of multiple means of assessing competence including case analysis, simulations, rating scales, and self-administered checklists are being explored. The relationships among the essential knowledge necessary to practice, the individual work experiences of the pharmacist, the practice environment, the necessary skills, and the influence that all of these factors exert on the actual work of the pharmacist in delivering pharmacy services are being carefully studied.

The practice model which is being developed for the competency assessment activity is situational. It is designed to "test" the knowledge and skills of the pharmacist by placing him in simulated practice situations. It will provide the pharmacist with an opportunity to find out what he knows, and how well he uses what he knows, under given circumstances. In addition, the model allows for the experience of the pharmacist to come into play. The Standards of Practice, which resulted from the joint APhA/American Association of Colleges of Pharmacy Continuing Competency Project, will be used as the framework for developing the practice simulations.

Chapter 15

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Chapter 16

CONTINUING COMPETENCE FROM A HEALTH INSURANCE INDUSTRY PERSPECTIVE

by

Daniel R. Thomas

Health Costs Stimulate Action

National health care expenditures have increased from 5.3 percent of the Gross National Product in 1960 to 9.1 percent in 1978. This percentage increase and the rate of escalation in recent years has caused the health insurance industry to become concerned.*

As health insurance companies have stepped up efforts to contain health care costs over the last four years, they have become much more conscious of their responsibility to become advocates for consumers of health care services. This consciousness has caused the health insurance industry, through the Health Insurance Association of America (HIAA), to look at the factors that contribute to the rapidly escalating costs for health services, to identify problems in health care delivery, and to suggest alternatives or seek solutions to those problems. Health manpower is a major consideration.

Manpower Costs

A major component of health care costs is attributable to health manpower. This is evident upon examining national cost figures. Those figures show that in 1978, 27.4 percent of personal health care expenses were attributable to professional services including physician, dental and other professional services that are billed directly. Unidentified health manpower costs are a major portion of the 39.5 percent of personal health care expenses attributable to hospital care that reflects the cost of nurses, allied health personnel and support personnel (58 percent according to American Hospital Association 1978 data).

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*Statistics used in this article are from Source Book of Health Insurance Data 1979-1980, Health Insurance Institute.

Because of the tremendously significant percentage of health care costs that are attributable to health manpower and in the role of advocate for health care consumers, the HIAA recognizes the necessity to look closely at the role of allied health personnel in health care delivery. An evaluation of health care personnel roles requires consideration of both the entry level of competency and continuing competency of personnel. Competency considerations take on added significance in the context of the increasing range of independent responsibilities of health professionals, the increasing willingness of physicians to delegate functions and the changing modes of supervision permitted by new technology, new attitudes and new treatment modalities or options.

Insurance Industry Concerns About Competence

The health insurance industry has concern that, while preparation for entry into health occupations may be adequate upon graduation, completion of licensure requirements or appropriate certification, inadequate attention has focused on continuing competence. Yet competence must be maintained throughout health careers for the safety and benefit of patients. The extent of this concern is reflected in the HIAA decision to work closely with the National Commission for Health Certifying Agencies as one method of addressing the problem of both entry and continuing competence of health care personnel.

From the health insurance industry perspective, society's goals should go beyond simple concern for patient safety, and continuing competency goals are designed for much more. There is concern about inappropriate procedures, inappropriate utilization of services and unnecessary testing or redundant testing as they impact on insurance and health costs. Health manpower competence is an important factor in providing quality health care.

Inappropriate procedures or testing are not only costly to patients who pay for these services, but may expose patients to unnecessary risks that are associated with those procedures. The health insurance industry is concerned about both the costs and the risks to patient safety. We encourage health providers to address both.

It is important that patients obtain care that positively contributes to their welfare and that accurate diagnosis, appropriate treatment and necessary services are provided. Failure to provide any of these may needlessly endanger consumers of health care services and inappropriately

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adds to the national cost for health care services.

On a practical level, bad health care management results in increased out-of-pocket costs to private pay patients and unnecessary premium rate increases to health insurance policyholders. For businesses and others, increases in insurance rates translate into increasing costs for employee benefits and resulting higher costs for goods and services. The vicious cycle must be broken and, to the extent that incompetence of health care personnel contributes to this cycle of cost escalations, the health insurance industry supports efforts to eliminate this effect.

Quality and Cost Options

Like others involved in health care, the health insurance industry has begun to consider the alternatives to traditional health delivery patterns in recent years. The Health Insurance Association of America is strongly supportive of innovations in delivery patterns. Indeed, individual health insurance companies support a variety of options to traditional hospital confinement for diagnosis and treatment, such as encouraging health education and life style changes, pre-admission testing, ambulatory surgery options, health maintenance organizations, home health care, and innovative approaches to care.

As the health insurance industry aggressively encourages consideration of new alternatives for care and treatment, it simultaneously is concerned that the care provided is of high quality and managed by appropriate institutions and competent health professionals.

The HIAA also supports efforts to protect patients by encouraging development of quality of health care programs for all patients whenever possible. Selected health insurance companies have established facility certification processes that evaluate facilities for patient services by looking at the physical plant, services available and the type of qualifications of health care staff available.

The health insurance industry will continue to pursue traditional methods that individual insurance companies undertake to assure that insured patients are treated in appropriate facilities with necessary staffing and resources. Nevertheless, the HIAA encourages professional associations and institutional providers to undertake innovative approaches to assure continuing competency of health care personnel. At this time, there is uncertainty about the best way to achieve that objective and uncertainty that any single approach will assure continuing competence.

The Industry's Questions

As we address the issue of continuing competency, a number of questions arise. Among the questions that health insurance companies and providers of health services may face in the future are:

1. What are the most productive processes for assuring continuing competence?

2. What should be the source of payment of continuing competence activities?

3. Does third-party reimbursement have a role in assuring continuing competence?

4. How can consumers be assured that credentials indicate continuing competence?

5. What percentage of the total cost for personal health care services can be reduced by eliminating or reducing health manpower incompetence?

6. How will continuing competence needs change as innovative health delivery options are undertaken?

Although the above questions do not indicate the full spectrum of continuing competency concerns, they are an indication of the deep interests of health insurance companies in the issue. In the future they may serve as the basis for activities by the HIAA and/or the NCHCA.

Chapter 17

THE EFFICACY OF CONTINUING EDUCATION

by

Peggy McCarberg

Continuing education (CE) is surely the best known and most frequently employed means of assuring continuing competence. So closely are the two concepts identified that continuing education is sometimes confused with continuing competence. (Broski, 1979) To avoid such confusion, it is appropriate to recall alternative means of continuing competence assurance, such as peer review, practice audits, and re-examination.

'Continuing education' refers to learning which occurs after one's formal education. It builds on the knowledge acquired for career entry. Thus, it excludes learning applicable to a formal entry degree or certificate. CE relates directly to professional competence by improving skills through knowledge reinforcement, mastery of recent developments, and review of new trends. This can be accomplished through seminars, conferences, lectures, home study, or other learning forums.

There is a tendency to encourage CE participation as though it were a goal to be attained by the conscientious health professional. The appropriate perspective is that it is a mechanism to be used to ensure practitioner competence while concomitantly improving the quality of patient care. Although it is laudable to realize that one's education is never complete, the ultimate goal of improvement of health care delivery must remain an essential feature of CE. Participation should be directed toward this improvement rather than merely fulfilling one's yearly CE requirements.

The Evaluation of CE

The current use of CE as a required means of updating knowledge originated in 1947, when the American Academy of General Practice, precursor of the American Academy of Family Physicians, placed in its constitution a membership requirement of 150 hours of CE participation over a three year period. Thus, family practice became the first medical speciality to impose a CE requirement. (Richards, 1978)

Family physicians proved to be the harbingers of a trend which did not become widespread until the 1970s. The Academy is currently one of seven medical specialty societies which require CE of their members. Virtually all 22 medical specialty boards have recertification plans for the future, of which 15 are scheduled to be implemented by the mid-1980s. (Ayers, 1980) All medical recertification programs, whether mandatory or voluntary, demand CE of participants.

The public sector has responded similarly to the family practice catalyst. New Mexico in 1971 became the first state to require CE for relicensure of physicians. (Derbyshire, 1979) As of January 1980, 20 states have adopted CE requirements of varying quantities for license renewal. (Ayers, 1980)

Continuing education for other health professions also has proliferated. States vary as to the amount of CE required, if any, for the professions they choose to license. Boards or agencies in 19 states have legislative authority to require CE of nurses under certain circumstances (e.g., for those not currently practicing or those returning to work after an extended period of time). Only three states demand it of physical therapists. Social workers in ten states must continue their education, whereas radiographers practice unencumbered by state-required CE. (Vogel, 1979) But, this is not to suggest that health professionals participate in CE only when required to do so by statute.

Professional societies are involved in several activities related to continuing education. Associations with a certification program frequently impose CE requirements: The Commission's 1979 report on Perspectives on Health Occupational Credentialing listed 20 certification programs, out of 42 supplying data, with recertification components. CE is used in about half of these recertification efforts. Other professional associations serve members through a variety of CE activities, such as program development, recognition of voluntary particiation, record-keeping for accumulated credits, and relevant information dissemination. (See Tables A and B which follow this chapter.)

Effectiveness of CE

With mandatory CE increasing, one may legitimately question the outcome of participation. Is knowledge related to practice measurably increased? Are skills improved? Do patients receive better care? A review of the available literature on the efficacy of CE leaves one with an unmistakable sense of uncertainty. The cogent study with irrefutable and generalizable results has not been conducted, and the wide-scattered data available from various research projects lead mostly to confusion, not clarity.

There is a growing concern that CE is ineffectual, and critics can find support for this view in the literature. A classic study of Kansas physicians spanning ten years demonstrated no correlation between perinatal death rate and CE courses in pediatrics and obstetrics. (Lewis and Hassanein, 1970) This was a strong indictment of the advanced learning process--mitigated perhaps by the largely social etiology of low birth weight and related complications--but the growth of CE since this report has been phenomenal.

Equally discouraging accounts of CE results were published throughout the 1960s. One article recounted the failure of CE to rectify practitioner habits in four different situations. (Miller, 1963) The author concluded that if learning had occurred, it was not translated into improved practice. The same author later decried the purportedly repeated failure of traditional CE to modify the inappropriate practice habits of physicians. (Miller, 1967)

Despite these reports, those who promote CE as an effective means of increasing practitioner competence can also point to studies which support their argument. One such study involved practicing physicians participating in CE through Stanford University. This "Back-to-Medical-School" program was based on a core curriculum similar to a medical school program but of particular relevance to physicians in practice. When the program at one California hospital had been established for two years, an evaluation of its effectiveness was undertaken. Laboratory procedures, drug administrations, and other measurable practices were analyzed. The positive results of the program did indicate that medical practice can be influenced by participation in formal CE courses. (Rubenstein, 1973)

Similar results were obtained in other studies. Two studies which found benefits of CE participation were formulated such that the relevant information presented in the course was tailored to a particular and narrow objective: a greater number of cancer patient referrals in one case and increased pressure monitoring in the second situation. Following CE on the particular topic, cancer patient referrals increased dramatically. (Mahon, 1978) An equally impressive rise in pulmonary artery pressure monitoring of patients was recorded following a program on catheter insertion in a second study. (Talley, 1978)

Those who view CE equivocally can look with assurance to the literature and find comfort in studies with inconclusive results. Research conducted in Texas attempted to discern nurses' attitudes following CE. In addition, performance changes and cost-effectiveness were evaluated. Ten different educational offerings were a part of the one-year project. The result was a mixture of encouraging and discouraging results. Problems arose due to the inadequate methods available with which to measure reliability and validity, although nurses' attitudes were easier to evaluate. Many questions posed at the outset went unanswered, but some small advances were made in the realm of experience gained for future research. (Deets and Blume, 1977)

A comprehensive overview of research done on CE was recently published. (Lloyd and Abrahamson, 1979) The authors reivewed 47 evaluation studies published since 1960. The results were categorized according to physician competence (capability), practitioner performance, and patient health status. In those studies reviewed, shortcomings were exposed: the absence of control groups, follow-up reports, or long-term results was common. In addition, alternative explanations could account for some of the research findings. Overall, the evidence accumulated will partially satisfy all viewpoints: CE participation apparently resulted in improved practitioner performance, competence, or patient health status in approximately 50 percent of the studies reviewed.

Improving CE: A Report on Interviews

A number of allied health professionals, educators, and government officials expressed their opinions on CE in response to questions posed in preparing this report. The telephone interviews revealed support for CE as a means of updating practitioner knowledge but with reservations.

Those interviewed believed that participation in CE proved beneficial in some situations. Although all interviewees expressed a degree of satisfaction with CE programs, the majority asserted that CE in its present form is indequate as a sole means of keeping practitioners current.

There emerged consensus that identification of practitioner needs is a barrier to effective program development. Although one health professional contended that practitioners can correctly identify their own deficiencies, others urged that more reliable methods need to be developed.

Testing participants in advance of education program development was suggested as a means of revealing areas of practitioner deficiency. Cognizance of when a practitioner entered the health field may assist in creating relevant programs, because recent graduates may not require the same degree or type of information as their senior associates. Additionally, information-sharing may be a vital part of the learning process: allowing time for practitioners to verbalize work-related problems following a lecture may provide mutual insight into professional needs.

There was unanimity in a plea for further research not only about the efficacy of CE participation, but also about the effectiveness of various methodologies. Traditional lecture-type formats appear inappropriate to many situations. The passivity of listening to a barrage of information received a great deal of criticism. Active participation in a learning situation through discussions, hands-on learning, and expedient impelementation of newly-acquired skills is seen as a more effectual means of increasing competence.

Although much criticism of CE in its current form was expressed by the authorities interviewed, positive suggestions for improvement were offered. Aaron L. Andrews, dean of the School of Allied Health at Ferris State College in Michigan, promoted an increased academic role in continuing education. While physicians may look at state medical societies for guidance, allied health professionals find no comparable system. Andrews suggested that academic institutions could fill that need if adequate funds were made available. He also emphasized that CE is only one facet of continuing competence.

Within the federal government, there is a perception of too great an emphasis on fulfilling CE requirements, as opposed to increasing practitioner knowledge and improving patient care. Robert Conant, Chief of the Health Personnel Standards Branch of the Division of Associated Health Professions in the Bureau of Health Professions, stated that learning should be adapted to individual needs. The Division's system of building CE begins with evaluation of the profession to determine basic entry-level requirements. An individual's performance is then reviewed for deficiencies based on these requirements. Self-paced learning modules are used to correct practice problems: the individual voluntarily works with the appropriate learning materials at a convenient time and suitable speed. This is a non-threatening means by which practitioners through self-assessment can control their learning environment.

Mandatory Versus Voluntary Measures

The debate centering on voluntary versus mandatory CE continues with no resolution foreseen in the near future. Requirements for CE participation are multiplying, yet arguments against it are beginning to take effect. Several states have been questioning the practice of requiring CE for relicensure, (Vogel, 1979) and professional organizations are analyzing the problem to preclude hasty decisions.

Both sides present effective arguments. The contradictory status of the available literature on the failure and success of CE provides useful data with which to argue.

The main argument proponents of voluntary CE rely on is the claim that people cannot be forced to learn. One must want to learn before a program can produce effective results. Being forced to attend classes only creates a situation whereby participants work to accumulate credits, not knowledge.

Further, established CE programs are said to channel professionals into rigid systems which are not only uninteresting, but also irrelevant. Voluntary participation allows preferences and requirements to prevail. (Novello, 1971) The contradictory results of CE research lend credence to the claim that if voluntary efforts in the past have failed to improve patient care, it is unreasonable to expect mandatory participation to succeed.

Those who favor mandatory requirements refute their opponents' claims with the following reasoning. There is no evidence that, without CE requirements, those who are in need of advanced learning will voluntarily engage in it. Insufficient dedication hampers an effective voluntary system of CE for all practitioners. Re-credentialing and mandatory education can only increase the quality of patient care, and exposure to information is better than no knowledge updating it at all. (Novello, 1971)

The pro-mandatory discussion continues with the argument that current problems in traditional CE can be rectified. Cogent research will reveal which methods of CE are effective in improving prctitioner knowledge. Appropriate efforts can result in a valid means by which to measure practitioner competence. Mandatory CE provides an impetus to develop new methodologies.

Conclusion

The debate over mandatory versus voluntary CE participation cannot be resolved without further research. The arguments on both sides are impressive but may be irreconciliable. While the redundancy of urging further research is undeniable, so are the exigencies. The studies reported thus far are contradictory and frequently invalid, and reliance on anecdotal experiences is ill-advised. Intelligent, informed decisions that will have a long-term impact on the health professions should be based on irrefutable data, which can evolve only through a concerted effort on the part of those most directly involved: health-care practitioners.

Table A. Selected Certifying Agencies and Professional Associations with Mandatory Continuing Education Requirements

Name	Hours Required	Period of Time	Remarks
American Board of Bioanalysis	4 C.E.U.	2 years	
American Board of Opticianry	9 C.E.C.	3 years	One C.E.C. = 3/4 hour
American Medical Record Association			
American Nurses' Association			Varies with each state
Commission on Rehabilitation Counselor Certification	150 hours	5 years	Exam allowed
Dental Assisting National Board	12 hours	Annual	Annual exam Allowed
Joint Commission on Allied Health Personnel in Ophthalmology	6-12 hours	Annual	
National Certifying Agency for Medical Laboratory Personnel	2 C.E.U.	2 years	Exam allowed for 5 year recertification
National Commission on Certification of Physician's Assistants			
National Contact Lens Examiners	15 C.E.U.	3 years	One C.E.U. = 3/4 hour
National Registry of Emergency Medical Technologists	48 hours	2 years	Refresher training and annual CPR certification required

Table B. Selected Certifying Agencies and Professional Associations Without Mandatory Continuing Education Requirements

American Academy of Orthotists and Prosthetists

American Association of Medical Assistants

American Association for Respiratory Therapy

American Board for Certification in Orthotics and Prosthetics

American College of Nursing Home Administrators

American Corrective Therapy Association

American Dental Assistants Association

American Dietetic Association

American Medical Technologists

American Registry of Radiologic Technologists

American Society for Medical Technology

American Society of Ocularists

Board of Registry of the American Society of Clinical Pathologists

International Society for Clinical Laboratory Technology

National Board for Respiratory Therapy

National Board of Chiropractic Examiners

Nuclear Medicine Technology Certification Board

Chapter 17

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Chapter 18

DISCIPLINE OF THE ERRANT HEALTH PROFESSIONAL

by

Peggy McCarberg

Discipline and Its Purpose

An area of health occupational regulation that merits, and can be expected to receive, enhanced attention in the future is discipline of the errant health professional. Although the term may refer to a variety of sins or problems, 'errant' is used here in reference to an individual who has become an incompetent practitioner over time for any reason or set of reasons or who has performed practice abuses intentionally or negligently.

Discipline relates directly to occupational credentialing. The meaning of a credential is diluted to the extent that the credential lacks relationship to the current competence of the holder. Discipline comprises the range of methods used for dealing with a credentialed practitioner who no longer is competent or deserving of the credential.

In discussion about professions, discipline surely is an unpleasant topic. Few professionals relish the prospect of judging a peer. To illustrate, lawyers complained for years about the "conspiracy of silence," a mere analogue of *omerta* that prevented physicians from being persuaded to testify against one another. (14 Clev.-Mar. L. Rev. 520 [1965]) One premise underlying such reticence is the awareness that medicine "is an art" with no absolutely clear-cut, preferred method of approaching a problem in the case of an individual patient, so that no one can say with confidence which method is the correct one. Peer pressures and empathy with the accused also inhibit speaking out against abuses in one's profession. (Green, 1978, and Zimmerly, 1978)

But, despite any artistic qualities of professional practice, there is a minimum level of proficiency that a patient expects of a health care worker who holds himself or herself out as a competent professional. The certificate on one's wall attests to the fact that one has met the minimum requirements of the profession. It is reasonable to expect the related abilities to be current, as the patient reasonably may rely on the certificate as demonstration of the skill that is being applied to the patient's case.

Discipline comprises an allocation of resources, and some would argue that a relatively low measure of incompetence among professionals--for example, the prevalence of physician incompetence has been estimated atfive percent--would suggest that energy spent in the pursuit of discipline could more profitably be used elsewhere. The health care system ought not to ignore, however, the extent to which five percent of practitioners touch the lives of a great many patients. (Derbyshire, 1969)

This chapter rests on the assumption that the purpose of discipline is not to punish the errant professional: It is to protect patients from potentially harmful treatment. When energy spent may prevent harm from coming to a patient or class of patients, such energy is being expended appropriately, provided that it is not being expended excessively. Moreover, establishment of a system of discipline will have some deterrent effect in discouraging practitioners generally from becoming lax in their knowledge, skills, and practice patterns. (Grad, 1979)

Within the private sector, professionals may be seen as owing themselves the effort required to rehabilitate errant colleagues. Even in terms of welfare economics and the allocation of resources, the amount of time, effort, and other energies invested in the training of students or employees to become qualified professionals renders discipine sensible. Discipline in the relevant dictionary sense is "training that corrects, molds, or perfects," and thus should comprise part of the continuum of health professions education as well as regulation.

This chapter considers the questions of who administers and should administer disciplinary action and what form such action may take. State licensing authorities, professional associations, certifying agencies, hospitals, and others have an interest in professional discipline. These interests and current roles are examined in the following pages.

State Licensing Authorities

For state-licensed professions, government agencies hold disciplinary authority. Such authority may be vested either in licensing boards or in an umbrella state agency. One *sui generis* model is that of New York State, where the Division of Professional Conduct maintains responsibility for discipline and reports to the Board of Regents. The Division investigates allegations of misconduct and enforces disciplinary actions which must have been approved by the Board.

When complaints are received either orally, through "hot-line" phone calls, or in writing, they are referred for investigation. Minor problems may be resolved informally by a department investigator, but more serious violations are handled by a three-member committee of the particular profession's state board. After consideration of the problem, an administrative warning may be issued by the committee or the matter may be referred to the attorney general for prosecution. If the problem merits this increased attention, the case is presented to a five-member panel. The decision subsequently reached by the panel is examined by the Regents Review Committee and ultimately by the Board of Regents. Penalties imposed by the Board may range from a reprimand to license revocation.

Improvements are being made in New York which will expedite case processing. In some instances, professionals may choose to surrender their licenses voluntarily or the Board may exercise emergency power to suspend a license immediately. In addition, legislative and executive agencies are working on proposals for further streamlining of the extensive hearing procedures. (New York State Education Department, Office of the Professions, Annual Report, 1979) Recent legislation consolidated prosecutorial authority in the Division of Professional Conduct.

New York is not the only state reacting to the discipline problem with new approaches. In 1975, California established the State Board of Medical Quality Assurance. At the regional level, Medical Quality Review Committees investigate complaints and refer serious violations to an administrative law judge. The decision by the judge as to disciplinary action is subject to approval by the state's Division of Medical Quality. Currently, an experimental study using "screening criteria" for substandard practices is being developed to strengthen further California's system of medical review. (Chapman, 1978)

The Virginia State Board of Medicine has undergone changes and been strengthened over the past 15 years. Many complaints of professional misconduct are resolved by informal decisions, but a special committee of three people responds to more serious violations. Should a practitioner decide to appeal the special committee's decision, the case is presented before a hearing officer of the State Department of Commerce. The Virginia State Board of Medicine and eventually an appropriate court may hear an appeal of the hearing officer's decision if the physician remains unsatisfied. (Carroll, 1979)

To prevent disciplinary problems from arising, many states mandate continuing education as a prerequisite to license renewal so as to avert incompetence. Should a practitioner fail to complete the requisite education, his or her license is not renewed. This clear-cut method--no continuing education, no license renewal--differs from discipline in that there is little gray area or room for dispute. (See Brown v. State Bd. of Examiners in Optometry, 263 N.W.2d 490 [Sup.Ct. 1978]) The state, in its capacity as protector of the public health, has the constitutional authority to issue licenses and so also may revoke them. (Cross v. Colorado State Bd. of Dental Examiners, 552 P.2d 38 [Ct. App. 1976])

State disciplinary action begins with a complaint. When the disciplinary authority finds that a complaint warrants some action, it may conduct an investigation or hearing or may refer the matter to another agency for investigation. Some role in discipline usually is exercised by the offices of state attorneys general, and their participation may be triggered as early as the investigative stage.

The accused in a state disciplinary proceeding is cloaked with considerable protection by the Due Process Clause of the 14th Amendement to the federal Constitution. The types of protection involved include the opportunities to: receive notice of the general prohibition and the specific violation and the time and place scheduled for a hearing; be aided by counsel; present evidence in one's defense (with or without subpoena authority); cross-examine adverse witnesses and hear their testimony, plus see all other evidence; enjoy an impartial hearing authority and a full and fair hearing; have the grounds for disciplinary decisions set forth explicitly so that they may be challenged; have the decision reviewed fairly; and face no punishment grossly disproportionate in severity to the offense. (8 Cumb. L. Rev. 295 [1977])

These protections, so eminently laudable in the context of state regulation, yield dilatory effects that frequently cause disciplinary actions to drag on for years and to exhaust huge quantities of public resources. Moreover, the effects of state disciplinary action are limited by the ability of the accused, even after being disciplined by a state, to establish practice without penalty in another jurisdiction. To date, states lack even a systematic method or network for communicating disciplinary information among each other, although the Council of State Governments currently is attempting to establish such a system.

The role of state licensing boards in discipline also may tend to hinder effectiveness. Licensing boards typically are composed mostly of members of the licensed profession with few if any lay members. This composition may promote a reluctance to judge too harshly, if at all. (Derbyshire, 1969, and Grad, 1979)

Other problems include the lack of trained investigators, lack of coordination among involved bureaucratic entities, the need to rely on individual complaints without investigating generic problems, the technical difficulty in framing the general grounds for discipline with constitutionally sufficient specificity to encompass individual incidents of malfeasance or non-feasance, confusion about the legal roles of authorities who serve multiple functions as investigators and prosecutors and judges, and the limited types of sanctions available given that loss of a license effectively precludes the accused from earning a livelihood.

Despite such abundant difficulties, state discipline is on the rise, but state action may not meet the full need for professional discipline. (Chapman, 1978)

Professional Associations

Professional associations that do not issue certificates attesting to professional competence generally have no mechanism for verifying competence at the time of entry into a profession or on a continuing basis. Such associations generally are not made aware of incidents of low-quality performance or care and therefore have no need to react to such incidents.

In recent years, however, associations have become increasingly involved in continuing education as an antidote to incompetence. As described elsewhere in this report, continuing education offers at least the potential for helping practitioners to maintain current knowledge and skills. But the application of knowledge and skills to practice situations is not monitored by associations, so that even members of groups with continuing education requirements as a condition for maintaining membership conceivably could fail to meet high professional standards in bringing appropriate and contemporary knowledge and skills to the care of the individual patient.

Some associations do have established codes of ethics. In fact, in the area of antitrust law, such codes of ethics recently have become controversial to the extent that they prohibit some economic practices, such as advertising, which may be in the public interest. Generally, such codes are broadly worded and speak to provider attitudes rather than on-the-job requirements.

Presumably, discipline by a professional association would be of limited significance. If behavior were exhibited that could not be ignored, a reprimand followed by expulsion if necessary is a predictable sanction. Without supplementary state action, a sanctioned individual could retain a license or other credential that serves as a precondition to employment, which membership in a professional association is not. For the majority of health care workers, professional association membership has little bearing on the work situation, so that even expulsion would have no real effect on one's practice unless coupled with the revocation of a companion credential. Indeed, because only about half of all professionals belong to professional societies, there probably is no important stigma attached to non-membership. (Grad, 1979)

An exception to the lack of teeth in discipline by professional associations is provided by medical societies in some juristictions. Although medical society participation is voluntary, statutes in some states vest certain powers in the society. In such cases, when a complaint is filed, a society may be required by statute to act on it, rather than to disregard it. Further, a state may require a society to report to the licensing agency problems which have necessitated disciplinary action. Some local branches of the American Medical Association--which is what medical societies are--have been designated to function as the disciplinary board for the state's physicians. (Grad, 1979)

More often, a local medical society will be at the opposite end of the disciplinary spectrum and be almost totally ineffectual with regard to discipline. Because membership is voluntary, the disciplinary role is necessarily limited to those who choose to be members, so that the affected practitioner population is relatively small. When disciplinary action is taken by a component of a professional association, the action generally takes place in isolation: Knowledge of the complaints and measures taken seldom go beyond the society itself. The latter aspect has good and bad elements. An informal, private inquiry may be the appropriate way to handle a particular complaint, but the isolation may make it convenient to avoid complaints in the interest of peer protection, so that in the absence of a statute compelling reporting, the state licensing agency may never learn of problems that would warrant official action. (Grad, 1979)

Overall, local societies have little effect on discipline of health professionals. Their actual power is limited, as is their interest in playing a more active role. Such organizations were not established to perform a policing function, and there is little impetus to change in this regard.

Hospitals

Discipline of errant health professionals is a matter of major concern to hospitals. A 1964 landmark malpractice judgment held hospitals legally responsible for the acts of their employees. (*Darling v. Charleston Community Memorial Hospital*, 33 Ill.2d 326, 211 N.E.2d 253 [1965], *cert. denied*, 383 U.S. 946 [1966]) When a malpractice action is initiated against a hospital employee, the hospital typically is also named in the suit. Hospitals thus have a great stake in ensuring the competence of their personnel and rehabilitating or sanctioning those who lack it.

Hospitals are uniquely situated to take preventive action with regard to professional competence. When an inappropriate behavior is observed, it can be corrected before it grows into a legal liability. Small infractions may be noted in a hospital, whereas in another setting they may go undetected.

Aside from malpractice concerns, hospitals must answer to state accrediting or licensing authorities as well as to private accrediting authorities. Some states require medical facilities to report all disciplinary actions taken which may prompt further investigation by a state agency. (Grad, 1979) Hospitals may be held responsible for their employees' actions through statutory changes being made in various jurisdictions. States such as New York and Michigan, intent on raising the level of patient care being delivered, have strengthened their hospital codes. In Arizona, hospitals have a statutory duty to continually review the care being rendered within their facility with the goal of improving the over-all quality. (Grad, 1979) Reflecting this increased responsibility, the Joint Commission on Accreditation of Hospitals recently has shown increased interest in the qualifications of hospital employees and may develop a similar interest in discipline.

Unquestionably, loss of hospital privileges or employment termination is an effective sanction, so that the disciplinary role of hospitals is considerable. However, such action does have its own limitations. It reaches only hospital staff and employees, not individuals who work in other settings. Due-process protection similar to that afforded the accused in state disciplinary actions may be applicable to hospital actions. Proceedings thus may be time-consuming and exhaustive or exhausting and bring adverse publicity to what is in part an economic institution. Finally, from the standpoint of the immediate protection of the public, sanctioned individuals still would be free to obtain employment or privileges in another institution or setting.

Professional Standards Review Organizations

Interest in maintaining high standards of professional behavior is inherent in the very name of Professional Standards Review Organizations (PSROs). PSROs are designed for the purpose of providing optimal health care at an affordable cost, but "(t)he ability of the PSRO and other peer review groups to sanction or discipline is crucial to the organization's ultimate effectiveness." (Blum, 1977)

When inappropriate behavior is revealed during review, the PSRO reacts in some manner. Such reaction may involve informal approaches as well as actual sanctions that could affect the practitioner's pocketbook. (Blum, 1977)

A PSRO medical audit focuses on specific elements of patient care, particularly the reason for hospital admission, procedures followed for the normal patient, and length of stay. (Grad, 1979) Although the emphasis is generally on the physician's role, unsound practices by other health professionals can also be exposed by a medical audit. Also, other elements of care, such as a nursing plan or physical therapy program, may be reviewed according to an established procedure or protocol.

When substandard performance is revealed, the practitioner is notified that his or her care appears deficient as measured against the PSRO standard. Notification alone often has the effect of modifying conduct in question. Records may be closely examined, and a PSRO may recommend or require continuing education of a practitioner or service in conjunction with a superior or consultant as a means of upgrading skills. (Blum, 1977)

Ultimate authority to sanction or discipline rests with the Department of Health and Human Services (DHHS, formerly DHEW). Available sanctions reflect the PSRO emphasis on cost containment: Suspension of Medicare or Medicaid payment and the levying of fines are typical penalties. (Blum, 1977)

PSROs may have the potential to become effective in professional discipline, but the full extent of their capacity is unknown. The law and administrative practices are still evolving with respect to PSROs, and the degree of power that the individual organizations may come to wield is extremely unclear. (Blum, 1977, and Grad, 1979)

In fulfilling a disciplinary function, PSROs may be hampered by confidentiality requirements (Grad, 1979) and by the medical audit method that reflect the procedures followed by groups of health-care practitioners rather than individuals. Thus, even re-training may be thwarted by the inability to focus on the person who needs attention.

Still, the fundamental PSRO goal of attaining high-quality care at manageable costs meshes well with the purpose of professional discipline. Audits and practitioner profiles may serve to help refine the performance of health professionals so as to achieve more efficient and reliable patient care. But, at this writing, eight years after the enactment of the PSRO Amendment in Public Law 92-603, the fate of these organizations remains highly uncertain.

The Role of Patients

One might expect that a consumer complaint ordinarily would focus attention on a health-care practitioner who would be an appropriate candidate for discipline. Surprisingly, however, the California Board of Medical Quality Assurance found in an investigation of patient complaints that only two percent involved disciplinary or quality issues, while the remainder reflected combined patient and physician discontent, inadequate communication, and disputes over fees. (McQuarrie, 1979) Results of this study thus suggest that patient complaints are not reliable indices of competence but rather mirror breakdowns in personal interaction between the provider and the consumer.

Lack of knowledge relevant to the grounds for discipline further limits the effectiveness of patients' role in identifying incompetence and violations of ethics. The average patient may be ill-equipped to recognize all but the most blatant examples of professional misconduct. Because the vast majority of patients receive at least adequate attention from providers, they may perceive little reason to increase their understanding of health care to the point where they can recognize insufficiencies or abuses.

Organization perhaps can help to channel consumer dissatisfaction for the purpose of monitoring competence to some extent. For example, prompted by a law suit initiated by the Pennsylvania Medical Society, the State Board of Medical Education and Licensure of Pennsylvania has initiated a program for training people of various backgrounds to become investigators of health consumer complaints, a program for which some positive results have been reported. (Chapman, 1978) Similar successes conceivably could be achieved in other states.

In the early 1970s, some hospitals experimented with establishing patient grievance mechanisms, partly to help contain the escalating medical malpractice problem. For the most part, such mechanisms, where put in place, were reduced through time to in-house consumer complaint bureaus with little clout. The failure of this idea to attain realization as a vehicle for consumerist reform can be attributed in part to lack of institutional commitment, lack of high professional status on the part of grievance officers, and a dearth of consumer support. The lesson applicable to discipline is that a program without teeth is not likely to earn the respect of practicing professionals.

Overall, the patient complaints may be of remarkably little help in identifying problem practitioners, despite the high degree of reliance on patient complaints inherent in state disciplinary programs. Frequently, personality conflicts provoke complaints largely unrelated to quality of care. Aside from complaining to state disciplinary authorities, dissatisfied patients and their families may seek relief in the form of malpractice judgments, but malpractice actions are severe in nature and represent only a small share of problems in the quality of care.

The Potential for Discipline in Certification

Interestingly, recent strides on the part of private certifying agencies to assure the continuing competence of practitioners have not included serious attempts to create and implement disciplinary programs. Continuing education, or re-examination procedures indicative of progressive programs, apparently are considered either sufficient to fulfill certification's responsibility for continuing competence or are deemed the best that can be done at the present time. For an agency to embark on a disciplinary program doubtless would be considered by many to constitute excessive zeal.

A paradox in the attitude of certification authorities is that, although certification is advanced as a measure of competence no less reliable than licensure in measuring practitioner abilities, certification lags far behind licensure in providing systematic ways to remove the credentials of practitioners who have demonstrated in cases of patient care that they do not adequately apply the knowledge which they are credited with possessing. Although some certification programs do not presume to issue credentials that mean anything more than that the holder has sufficient knowledge and skill to practice an occupation or be recognized as having excellent qualifications in a specialty area, the fine distinction between possession of knowledge and its appropriate application surely would be lost on the great host of consumers, who ultimately are the individuals who rely on certification as a measure of competence. From a consumer viewpoint, it may make little sense to allow an individual to retain a credential attesting to competence after the individual has been shown to be demonstrably incompetent. In this view, discipline in certification may be one way of strengthening the link between the possession of knowledge and skills and their application.

Conceivably, discipline in certification would have several advantages over discipline in licensure, which it necessarily would supplement. First, whereas the sanction of removal of one's license has the draconian effect of loss of livelihood, removal of a certificate would have much less legal effect and thus would lack the character and stigma of a criminal sanction. Second, the full panoply of due-process protection accorded the accused in a state disciplinary proceeding need not be brought to bear in the certification sphere, so that, although there would be ample protection, proceedings would not be inordinately complex or protracted. Third, investigative strategy on the part of certifying agencies could differ markedly from that of state disciplinary programs, so that there could be less reliance on individual complaints and more vigorous inquiry into generic practice questions, such as excessive exposure to radiation or improper administration of a particular procedure. Fourth, discipline in certification could be conducted primarily by members of the profession involved, without the presence of an adversarial relationship between the profession and public officials. In short, discipline in certification would comprise an opportunity for a profession to promote quality within its own ranks.

Embarking on a disciplinary program would be costly. Investigations, hearings, and reviews all would expend vital resources. But, sharing of common resources, particularly with regard to investigations, could yield tremendous savings. Also, volunteers within professions and indeed within the locality of the purported violator could meet informally and privately with the individual under suspicion and could implement a probationary program involving upgrading of knowledge and skills or agreement not to replicate ethical violations, without the necessity of subsequent disciplinary hearings and the involvement of attorneys and other specialized personnel. Discipline in certification, after all, could be primarily educational in character. And, it could result in substantial enhancement of the credibility of the health professions involved.

The National Commission for Health Certifying Agencies has not yet adopted a formal position with regard to discipline in certification. Because this may be an appropriate area for Commission endeavor, a position statement on discipline may be issued by the Commission in the near future.

Legal Ramifications of Discipline

Within the scope of this report, it is not possible to describe all the legal considerations involved in disciplining the errant health professional. Procedures vary with each situation, according to the work setting, the nature of the disciplinary authority, the severity of the alleged offense, the position or status of the accused, and the applicable state law. Court rulings do suggest some fundamental guidelines, however.

Because the revocation of a license directly affects a practitioner's livelihood, state licensing revocations frequently are brought to court for judicial review through an action filed by the licensee. There, a person's right to practice a profession is balanced against the state's right to protect public health by regulating professionals through licensure.

Depending on the particular situation, there are a variety of procedures that may be required for disciplinary action to take place. In general, the more a judgment would impinge on the ability to practice a profession, the greater the procedural safeguards that would be required. (Rehman v. California, 85 S.Ct. 8 [Douglas, Circuit Justice, 1964])

In state licensing disciplinary proceedings, the licensee is assured of such protections as receiving notice of a hearing, the opportunity to present a defense to charges made, and a fair decision based on evidence. (8 Cumb. L. Rev. 295 [1977]). Flexibility about the degree of protection that must be afforded allows for circumstances to dictate the precise requirements. For example, a practitioner's incompetence may prove so dangerous to patients that immediate license suspension without 30 days notice or a hearing is permissible. (Colorado State Board of Medical Examiners v. District Court, 551 P.2d 194 [Sup.Ct. 1976])

From the perspective of disciplinary authority, courts may be seen as interfering and tending to overrule proper administrative decisions. Also, it may be frustrating to the disciplinary authorities to hear of judges allowing a professional to continue practicing while a case is under review, a determination that reflects a court's awareness that license revocation is a serious situation. (Derbyshire, 1969) Underlying that type of decision is the court's knowledge that some damage will occur regardless of the final decision. If a practitioner is barred from working during the pendency of the court case (and court delays are notorious), he or she would sustain irreversible losses. But if the disciplinary decision is affirmed and it is found that a practitioner is not fit, a patient or patients treated while the case is pending could sustain irreversible injuries.

In private, as opposed to state, action, courts tend to require less protection of the accused. Thus, a physician expelled from the American College of Surgeons in a proceeding that lacked the formal character of a "trial-type hearing" failed to obtain judicial relief. (Duby v. American College of Surgeons, 468 F.2d 364 [7th Cir., 1972]) However, individuals are protected from arbitrary judgments even on the part of voluntary membership associations. For example, a local medical society's decision to exclude or expel practitioners can be reviewed in court and may be struck down if capricious.

In private as in public actions, the level of judicial scrutiny applied to a review of a disciplinary decision depends on the gravity of the situation. As a rule, courts hesitate to interfere if a society's constitution and bylaws were observed in reaching a decision, even if technical errors would have voided the decision had it been a judicial hearing. (Kirk v. Jefferson County Medical Society, 577 S.W.2d 419 [KY. App., 1978]; Blende v. Maricopa County Medical Society, 96 Ariz. 240, 393 P.2d 926 [Sup.Ct., 1964]; Ill. Bar J. 52:842 [1964]) If, however, one's pursuit of a profession is effectively denied by deprivation of society membership, the court will review the proceedings closely. (Falcone v. Middlesex County Medical Society, 34 N.J. 582, 170 A 2d 791 [1961])

Legal ramifications also exist for hospitals. Health care facilities bear increased responsibility for patient care in the wake of the 1964 decision, Darling v. Charleston Community Memorial Hospital (supra). This landmark case established the principle of hospital malpractice liability to a patient for the acts of its employees, under the tort law theory of respondeat superior. Hospitals now tend to be viewed by courts as integrated and complex institutions with many people involved in a patient's care. Hospitals bear ultimate responsibility as coordinators of health care activity, particularly when required by statute to supervise the overall quality of care.

Disciplinary actions by PSROs also may be reviewed in court, as when a physician is sanctioned by DHHS. There is little case law on the topic as PSROs are relatively new, but physicians denied Medicare or Medicaid payments by the Department may be expected to raise due-process issues in court. Because income restriction has a direct bearing on a physician's practice, even informal PSRO investigations should be conducted with caution and with sufficient protections to survive a court challenge. Thus, adequate notice along with other basic elements of dueprocess are requisite. (Blum, 1977)

As this section suggests, recent case law on disciplinary actions has focused on procedural protection as required by the Due Process Clause of the Constitution. This is in line with contemporary recognition of the importance of such protection, following a famous admonition in an opinion by the late Justice Frankfurter that the history of liberty in this country is in large measure the history of procedure. (Joint Anti-Fascist Refugee Comm. v. McGrath, 341 US 123, 71 SCt 624 [1951], J. Frankfurter concurring at 149) The problem from the point of view of disciplinary authorities is not that great care must be taken to protect the rights of accused individuals, but rather that the precise nature and degree of protections that a court will find necessary in a particular case are not known beforehand or anywhere listed. Instead, judgments about the degree of protection required depend on circumstance. Questions necessarily arise about whether an accused individual is entitled to a particular delay, to present a case in person before a review board, or to have overturned findings of violations of such vague proscriptions as "professional misconduct." To minimize procedural problems, disciplinary authorities may be advised, and private agencies may be better situated, to issue sanctions primarily in the form of educational and other probationary requirements that would necessitate fewer procedural safeguards in the balancing of harm to practitioners from disciplinary action against harm or potential harm to patients.

Conclusion

Discipline is not meant to be debilitating but rather to foster retraining and assistance of those in need. Effective revocation of the right to practice is evidence of a failed attempt at rehabiitation of an errant health worker, so that license revocations should not be tallied with smug satisfaction as proof of success of a disciplinary program.

Accordingly, license revocation should be the final step in a long process of efforts to update the knowledge and skills of a health worker. Discipline may begin with a candid discussion with an individual at an early indication of incompetence. Perhaps an isolated error in judgment was made, something not unheard of in the complex health care arena, and the mere mention of it may prevent a recurrence.

Conversation about a specific error or series of errors may not be easy. When confronted with allegations of incompetence, individuals may become defensive, even hostile. Co-workers may resent what they perceive as unfounded attacks on their ability by a peer or a superior. But, professional sensitivities ought not to thwart patient protection.

If discussion is ineffective and the problem appears to persist, further action may be necessary. Formal reprimands may be administered and recorded in an employee's personnel file. An employer or peer group may demand continued education. A consultant or supervisor may be chosen to work closely with an individual to monitor behavior and provide guidance. Or, a worker may choose voluntarily to limit a range of duties to compensate for decreased capabilities.

The revocation of a license is an unsatisfactory result for all concerned. The public loses the care of a health professional, the school or employer loses the benefit of time and money spent on training, and the sanctioned individual loses the right to practice.

Avoiding this scenario should be the goal of all health professionals. Societies and organizations need not approach professional discipline with dread of the consequences. For the goal of discipline is not destruction of incompetent individuals, but rather retraining or rehabilitating while it is still possible. The goal, after all, is to correct minor deficiencies before they cause irreparable harm to all involved.

Chapter 18

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Chapter 19

THE 'CHOICE' METHOD:

MEETING TODAY'S CONTINUING COMPETENCE IMPERATIVES

by

Neil Weisfeld and Dennis Falk

The Crossroads

Accomplishments and trials in continuing competence assurance described throughout this report are remarkable on at least two counts. In the first place, given the recent origin of even the notion of continuing competence as a dynamic feature of the professions, the widespread adoption of continuing education requirements and the frequent and innovative use of self-assessment and other techniques in recent years are startling. But, in the second place, no clear trend has emerged in the development of policies to assure continuing professional competence. Continuing education requirements, mandatory or voluntary, have served as a compromise or interim measure, of mainly undemonstrated efficacy or cost-effectiveness, that relatively quickly have become part of the health professions landscape but are probably too crude to survive as long-term policy approaches.

Today we are at a point where the assurance of continuing competence is a vital component of federal, state, and voluntary occupational credentialing programs. We now must decide in which direction to construct a route, or system of routes, toward continuing competence assurance. Possible routes include continuing education (whether mandatory or voluntary, certified or not certified), self-assessment, re-administration of an entry-level examination, administration of a mid-career examination, peer and audit review, proficiency examination, computer simulation, "in-basket" exercises, and individual portfolios. Construction along some of these routes already is fairly well advanced, while for others it has barely begun. Our present point of decision is a crossroads, because no course has been decided on and because government agencies and rising public expectations, articulated both inside and outside government, demand forward movement.

To some observers, change may seem slow in coming. The American Board of Medical Specialties is in its second decade of efforts to lead the specialty boards to adopt requirements for board-certified physicians. Similarly, adoption of new requirements by state licensing boards have not been breathtakingly sudden, although Michigan's new approach may lead to accelerated legislative efforts. In a longer historical context, however, these changes represent an entirely fresh approach undermining the concept of once-in-a-lifetime credentialing. This is a policy shift of a scale at least equal to the abolition of licensure in Jacksonian times, its re-imposition in the late 19th century, and the credentialing innovations accompanying the Flexner reforms. A transition period of ten or 20 years, in which the change to periodic credentialing is made virtually complete, is itself dramatic.

Still, such total change is hardly inevitable. The great, lingering problem of which method or methods to adopt to assure continuing competence must be resolved on some basis, in order to complete the change. Also, continuing competence developments have been accompanied all along by the continuing skepticism, sometimes the active opposition, of members of the professions themselves, who see little value in additional educational or examination requirements. requirements. So, we conceivably could turn back, although such a return to the once-in-a-lifetime approach surely would do severe damage to the credibility of credentialing systems of the health professions as a whole, and probably would not long be tolerated by legislatures and regulators.

This chapter presents a unified strategy for moving ahead. It is a strategy of combining routes, because no single route is now sufficiently appealing or inviting to all, but it is a strategy that should complete the change faster than any other way by mobilizing the greatest potential supply of mustered commitment and individual involvement. It relies on choice.

Requirements of an Effective System

There is much division of opinion about the efficacy of alternative mechanisms of assuring continuing competence and about the appropriateness of imposing any of these methods as a credentialing requirement. Similarly, opinion is divided about: (1) the respective roles of the public (licensure) and voluntary (certification) authorities, (2) the scope of a credential in terms of generalist and specialist fields of practice, and (3) the precise relationship of continuing competence assurance mechanisms to professional discipline or enforcement programs. On some matters, however, opinion is whole.

The following numbered paragraphs contain statements which are not likely to be disputed in their basic thrust by a large proportion of commentators or interested parties. These statements should be useful as postulates in the development of a solution to the policy question of how to assure continuing competence. They are not hard-and-fast rules, but rather are designed, or at least intended, as principles reflecting the current state-of-the-art. The so-called postulates themselves are the underlined portions of the paragraphs.

1. The continuing competence assurance system should promote education through the duration of one's professional life. The idea behind continuing competence assurance is that technology is changing so rapidly, and the composite knowledge and skills of a contemporary profession are so comprehensive, that a demonstration of competence at the beginning of one's career by no means assures a similar level or degree of competence very much later in one's career. Technologic change and additions to the body of knowledge within a profession are incorporated into the professional's area of expertise through some style of education, whether formal or informal, recorded or unrecorded. In serving the public interest, the basic function of continuing competence assurance mechanisms is to promote education appropriate to one's career throughout that career; the purpose is not to create arbitrary requirements or to enhance professional prestige.

2. The system should use meaningful incentives rather than unrealistically harsh sanctions or requirements so easily met as to be insignificant. Government regulation in general has been criticized throughout the 1970s, both by those who believe that it serves primarily the interests of the regulated group and by those who believe that it generates excessive and picayune requirements. The contemporary approach is to replace absolute, regulatory restrictions with structured incentives that encourage changes considered desirable from a public policy point of view (without stifling beneficial competition). This approach appears particularly applicable to the continuing competence area of occupational regulation, because it would tend to avoid the twin perils of: (1) removing one's right to earn a livelihood merely because at one specific time one failed to demonstrate competence, or compliance with surrogates of competence, in the scope of practice of an entire occupation, and (2) the establishment of requirements so easy to meet, or of such undemonstrated validity and reliability, that their adoption would lull people into a false sense of security concerning the value of credentials in protecting the health of the public.

3. Certificates of continuing competence should provide employers, third-party payors, health care providers, and the public some valid, reliable indication of an individual's areas of continuing competence. Just as occupational scopes of practice are not static, neither are they uniform across members of an occupation. To use common illustrations of this point, there may be little reason for a psychiatrist to maintain clincial competence to obstetrics, or for a family physician to be clinically competent in neurosurgery. Insofar as is practicable, the continuing competence certificate should cover the actual scope of practice of the certificant. Then, it will be of maximum use to those

who must rely on it as a sign of competence as measured by performance. If the mechanism used to assess continuing competence indeed measures what it is supposed to measure, that is, it assesses relevant components of competence, such as skills and knowledge, and measures actual individual capacity with respect to those components - then it has validity. If it has consistency (so that, for example, the same individual applying the same extent of effort would have only a slight possibility of being judged competent in one administration of a mechanism and incompetent in another administration, absent significant differences in skills or knowledge or other components of competence between such administrations), then it is reliable. In credentialing, validity and reliability typically are used as standards for examinations, but the concepts are equally applicable, if more difficult to apply, to the full range of competence assurance mechanisms.

4. The system for assuring continuing competence should be justifiable in economic terms. The wise allocation of resources - often rather redundantly called "scarce" resources - has gained fresh recognition of importance as our economy has confronted continuing challenges of inflation and lack of real growth. Government programs, especially, have been asked to justify themselves by showing benefits that are at least equivalent in some way, although not always commensurate, with their cost; many people implicitely use the benefit-cost formula as a test of "cost-effectiveness," which can be refined by determining whether alternative programs could yield either greater benefits at equivalent costs or equivalent benefits at lower cost. Continuing competence programs, like others in the public or private sectors that are intended to attain publicly beneficial results, should be held to the same basic test. Moreover, credentialing mechanisms and education programs created by the continuing competence assurance system should be used rather than lie idle and should be sufficient to meet demand across professions and across the country. But most importantly, the use of these regulatory and educational services should fulfill their intent - that is, they should directly increase or indirectly promote continuing competence.

5. Requirements must be acceptable to the professions. It is a political truism, that coincidentally is axiomatic in the sociology of the professions, that professional credentialing mechanisms and requirements are established by, or at the prodding of, professional associations and organizations. With precious exceptions, licensing and certification systems are not established or substantially altered because of input from public-interest groups or through a desire to check the interests or advantages enjoyed through membership in a profession. It is asking too much of credentialing mechanisms, therefore, that they impose continuing competence requirements that are anathema to their own professional constituencies. Requirements,

instead, must be non-threatening; they must not suspend a sword of Damocles over the necks of entire occupational populations by jeopardizing the practice privileges of large, influential blocs in an occupation. Moreover, requirements must not be excessively burdensome or unfair to large components of occupations in terms of time that must be expended to comply, fees that must be paid to have a credential updated, or distances that must be traversed or plans or scheduling commitments cancelled due to limited availability of program opportunities.

6. Credentialing programs should be updated periodically in terms of practice domains. Like item number 3 above, this is largely a matter of validity. The requirement of continuing competence is as applicable to credentialing mechanisms as it is to the individuals subjected to them. It would make little sense to issue a certificate of continuing competence on the basis of attainment of skills and knowledge that are no longer relevant to professional practice. Thus, every few years as appropriate from occupation to occupation, the scope of practice of the group covered by a credentialing mechanism (whether it measures entry-level or continuing competence) should be re-examined to assure relevance of the tested, learned, or demonstrated subject matter to the practice domain. Because of the expense and other resource constraints involved in identifying a practice domain that typically will include hundreds of items in the case of a profession, it is necessary to include large numbers of practitioners, generally with significant differences among them in knowledge and skills used, in the same mechanism; necessarily, therefore, credentialing systems are imperfect, but regular review is a fair antidote to such imperfection. Similarly, the mechanisms used by a profession should incorporate appropriate distinctions among generalist and specialist practice patterns.

7. The system should incorporate and encourage improvements in the technology of measurement and evaluation. The imperfection noted in the last item, and companion imperfections resulting in other difficulties in obtaining or demonstrating validity, may be alleviated to a significant degree through future technologic change. The measurement profession itself has been changing rapidly in recent years, and its increased sophistication should be promoted by credentialing systems or other sytems that make judgments on the basis of test results. Some of the changes may result in more accurate predictions of performance, while others may result in less costly evaluation mechanisms. Both types of change are highly desirable and could allow us to rely increasingly on objective measurement in awarding certificates of continuing competence. Although the widespread use of tests in society is controversial, abuses in the use of tests would be reduced, rather than increased, by improvements in testing technology.

8. Continuing competence assurance should be linked to disciplinary programs. Commonly, licenses and certificates are awarded and maintained through programs that are not coordinated effectively with disciplinary, or enforcement, efforts. Such linkage is essential, though, to prohibit an individual from misrepresenting his or her certificate status, to prevent individuals whose incompetence has been demonstrated from retaining credentials attesting to continuing competence, and to relieve the disciplinary system of the burden of identifying areas or ways in which members of a specific occupation are incompetent. Although the lack of such linkage may have been acceptable in the days when certification represented merely entry-level competence, the use of a certificate as a symbol of continuing competence assumes that knowledge, skills, and practice habits are current and adequate. The task of disciplinary authorities in identifying and sanctioning the occasional miscreant would be lessened considerably, and the public health protected better, if credentialing authorities would act to reduce: (1) opportunities for practice negligence caused by a failure to keep abreast of developments in one's profession, and (2) the possibility of one's holding onto a credential that should have been removed.

A system that incorporated all these principles in acting to assure continuing competence could be considered successful. Any such system that failed to incorporate even one of these principles would face serious problems.

Characteristics of a Desirable System

Achieving the requirements enumerated in the previous section is a complicated undertaking that could be performed in different ways. One approach, favored here, is to develop a system of continuing competence assurance that contains the following general characteristics.

Voluntary Participation. The old saw that "you cain't force somebody to learn" is an exaggeration with a kernel of accuracy. Even more to the point, it would virtually require turning the credentialing system on its head to compel established practitioners to forfeit their fundamental right to practice because of their performance in an examination. (Analogously, this is partly why the logging of continuing education credits has been used as a relatively inoffensive surrogate for more meaningful demonstrations of continuing competence.) The certification system, because it is voluntary, is in a position to impose requirements more stringent than those that may be acceptable in the licensing sphere. In addition, voluntary programs can be afforded greater leeway in innovation, because the sanction of the loss of a certificate is less harsh than, and thus need not rest on so firm an empirically justified footing as, the loss of a license.

Please note that we are favoring and characterizing voluntary participation as a private-sector activity. We are not suggesting that an individual should be allowed to opt out of all continuing competence programs and still retain certified status.

In characterizing certification as the voluntary complement to public regulation or licensure, we assume that all major health occupational fields would maintain or have maintained for them a certification program, whether or not the field is also affected by licensure, or milder regulatory alternatives to licensure, in a critical mass of states.

Licensure serves the purpose of assuring the public that practitioners of a licensed profession have achieved the extent of competence minimally necessary for safe practice. To illustrate the separation between licensure and certification, the National Commission for Health Certifying Agencies would not presume to instruct licensing authorities on how to adjust the licensing system to assure continuing competence. It is sufficient for the Commission to note that it enjoys opportunities for constructing an imaginative approach or at least one that is more flexible than what the licensing system may be able to develop in the near future. Of course, it is highly desirable that the licensing and certifying systems be complementary, or at least not contradictory, so some coordination is essential.

Emphasis on Self-assessment. Much has been said, in this report and elsewhere, about the role of a continuing competence system in assuring the public - and employers and third-party payors - that practitioners are still competent at the time of rendering service. That role is not lessened by a recognition that the system also must serve to help inform practitioners themselves of their relative strengths and weaknesses. Conceivably, such information may take the form of feedback supplied as part of examination programs, but in many cases that would be too late: the practitioner would have had to sit for the examination without knowing in advance his or her strengths or weaknesses in terms of examination content areas, so that individual study for the examination might not have been very efficient and preventable scars could develop from low scores. Self-assessment offers advantages in preventing these untoward effects: it allows the practitioner to work on continuing competence at convenient times and places; in some cases, it produces potentially immediate effects on one's practice by avoiding delays necessitated by reporting of examination scores; and it provides more precise feedback than would be afforded by overall scores (or by general impressions of continuing education sessions).

The important caveat to a reliance on self-assessment is that this method should not be used to the exclusion of others. There must be an incentive for the practitioner to improve competence to the point where a high score is achieved on self-assessment instruments. Such incentives may be provided most easily through follow-up formal examinations.

Functional Orientation. Continuing competence, like competence per se, is a term with myriad interpretations. This proposal envisions continuing competence as the individual capacity to perform - or, even better, the actual performance of one's professional work according to a standard of practice that is no less than that required for minimally acceptable safety. This view focuses on performance on the job rather than performance in a domain of behaviors that is generally applicable to an occupation. To illustrate, as in requirement number 3 above, a person who is and wishes to be classified as a generalist in an occupation should not be required to make a showing of specialist skills and knowledge, nor should a specialist practicing in a limited scope be held to a generalist standard. The certificate of continuing competence must be relevant to real-life practice in order to be useful to practitioners themselves, employers and third-party payors, and the public. Of course, examinations cannot be tailored to individuals, but rather must be assembled on the basis of domains of practice generally relevant to a large number of potential examinees.

The appropriate response to these problems is to structure examinations or other assessment instruments or programs along functions, using the term 'function' in the sense that it is a range of activity that is narrower than the scope of practice of an entire occupation but broader than a specific task. Functions would vary in scope from occupation to occupation: a function in the profession of medicine probably would be a whole lot wider than a function for a typical allied health occupation, because physicians tend to have an extremely broad practice domain. In all occupations, however, the candidate for continuing competence certification would have a choice of functions in which to demonstrate competence, and would choose at least a minimal number of the functional areas offered.

Ultimately, the reason for making functions the basis of content is to afford practitioners the opportunity to demonstrate competence in those functional areas that are relevant to their practice. Specialists who do not wish to do so would not have to demonstrate generalist skills, nor generalists specialty skills. Instead of continuing competence being identical in substance to entry-level competence, the entire notion of continuing competence would reflect the realization that competence is dynamic, changing during a career as an individual is channeled into particular practice directions.

The specification of functions in a profession requires an extensive commitment on the part of the profession as a whole. Ordinarily, a role delineation study would be performed, using a large sample of practitioners willing to participate. Experts would be empaneled to make, affirm, and evaluate decisions. The total effort would consume a large share of resources of professional organizations and could create risks to the profession's image. But, the achievement and utility of the delineation of specialties and functions should create practical gains outweighing the risks and costs. Among these gains would be a reduction in vulnerability to legal challenges to the certification program, heightened prestige among professions, more accurate labeling in job descriptions, greater opportunity for job-relatedness in the content of education and training programs, a comfortable fit for the individual in most continuing education and assessment programs, facilitation of inter-professional practice arrangements, and the enhanced protection of the public resulting from more accuracy and precision in certification.

Pluralism. One artifact of the continuing competence debate thus far has been the endeavor to arrive at the best or most appropriate method of assuring continuing competence. This effort is analogous to the divergent attempts by advocates of alternative forms of energy to advance one particular form as the basis of a solution to the nation's dilemma of depleting energy sources. In both cases, a unitary approach is not at all indicated, given the lack of lack of evidence and the surfeit of doubt concerning the viability of each approach to competence assurance or source of energy. Indeed, the strength of the health care system in the United States traditionally has been a belief in pluralism that allows different styles of delivery of services to coexist in an harmonious, if not always synergistic, manner.

Pluralism can operate on two levels in a continuing competence assurance system. Within an occupation or certification program, it can serve to allow individuals to choose among mechanisms in attempting to demonstrate competence, to their satisfaction or that of others. For example, one person may prefer a structured recertification examination accompanied by an appropriately designed regimen of continuing education, while another may choose re-administration of an entry-level certification examination accompanied by a practice audit. Because we do not know which of these approaches is more likely to improve outcomes in service delivery, there is no particular reason to force each individual to submit to one instead of another. On a "higher level," among occupations and certifying agencies, diversity should be not only tolerated but also encouraged. One group may prefer to include, as one component of its program, mandatory continuing education requirements, because it believes that continuing education programs available to the group are competence-based, effective, and worth a heavy commitment of resources. Another group may find itself highly skeptical about the value of continuing education programs available to it and instead may choose to develop a sophisticated array of self-assessment instruments. Who, today, can say which approach would be better in all cases?

A Goal of Excellence in Practice. One of the difficulties faced by certification authorities in recent years has been confusion over the idea of certification, resulting from the conflicting perceptions that certification is either: (1) a mark of basic competence, or (2) a mark of excellence in a profession. (Often the first of these perceptions is associated with general certification, while the second is related to specialty certification.) The National Commission for Health Certifying Agencies tends to find the debate between proponents of these two viewpoints not particularly useful. We all believe that certification should be available ultimately to all members of a profession, and we believe that certification should be an award that signifies excellence in protecting the public from unacceptably unsafe practices.

The role of continuing competence and continuing education, as opposed to entry-level credentialing and education prior to practice, is to facilitate improvement and the maintenance of skills on the part of the practitioner who, one hopes, is already highly competent in most activities undertaken. Therefore, it is fair to expect all practitioners participating in a continuing competence program to use that program, first, to identify areas of relative weakness or types of skills or knowledge that should be shored up, and second, to work to obtain a satisfactory or outstanding level of competence in areas thus identified. It is unrealistic to hold practitioners to any standard approximating perfection, either before or after participation in the program. As much as possible, it would be desirable to allow practitioners to choose their own method of improvement, as the American College of Nursing Home Administrators has undertaken to do.

What this approach suggests is that there is no single, sure road to excellence. Rather, the choice of route, within defensible limits, best rests on an individual basis, within terrain charted by the certifying agency or professional association with which the individual properly identifies. For that reason, it is an approach characterized above all else by the aspect of choice.

The Proposed Strategy and its Advantages and Disadvantages

The approach suggested here can be summarized in a paragraph. Each certification agency or program makes and implements four types of decisions. (1) It identifies for each occupation involved a series of functional areas, such as generalist and a handful of specialties, in which continuing competence will be demonstrated. (2) It selects, and decides to commit resources to, the method or combination of methods of continuing competence assurance that appear to offer the most promise and the greatest yield to the occupations involved, such as voluntary or mandatory continuing education, self-assessment, practice audit, administration of a written entry-level examination, administration of a different written examination, oral or proficiency examination, or portfolio. (3) It determines the showing that will be required of each individual with respect to such methods, such as a particular score, reasonably and statistically arrived at, on an examination, or a level of participation in continuing education programs, or perhaps a compliance plan, approved and then completed, for making improvements in areas identified as those where improvements are indicated. (4) Finally, it decides how it will evaluate its own continuing competence program regularly and with an eye toward constant improvement, especially, insofar as possible, in outcomes of service delivery.

With respect to one consideration, the agency need make no decision: in all cases, the information publicly disseminated by the agency concerning individual performance should be limited to certificates listing functional areas for which competence has been demonstrated and presenting a fixed date of expiration. The certificate should not list areas in which a showing of competence was attempted but not achieved, the method or methods used to evaluate continuing competence, or an exaggerated claim of the significance of the showing of competence. The agency should protect confidentiality rights, and it must not encourage observers to make comparisons in level of competence between certificants on the basis of the continuing competence method chosen.

Each of these four types of decisions will be difficult to make. The "choice" method described by this listing of decisions may be more difficult for a certifying agency to implement than a more rigid prescription might be. It reduces policy-making to the agency level, and policy-making always is an experimental process that exposes one to seemingly unfair criticism.

But, the advantages of this method, especialy as it includes self-assessment, are significantly greater than the advantages of its more limited alternatives. It is particularly non-threatening to practitioners, who would not have to dust off college textbooks in order to re-learn information that their practice situations permitted them to forget years ago. The employers, third-party payers, patients, and other publics that would hope to rely on certificates of continuing competence would appreciate their being oriented to functions in which the practitioner is in fact engaged. The individualistic nature of the continuing competence program should serve as a forceful incentive for practitioners to act to assess their own competence and seek to build on it. Using a variety of methods will promote research and development in all of them and will prevent the system from being a house of cards that could tumble when a single study debunks the value of one particular method. Agency choice in decision-making should put financial incentives where they belong and promote cost-effectiveness. Continual evaluation also should promote economic efficiency as well as improvements in quality. And, the entire field of continuing competence would remain a theater of creative activity, a scene of innovation in which ferment and the competition of ideas should benefit the public in the long run.

The prospective disadvantages, however, are not limited to difficulties in agency decision-making. All this creative ferment, all this innovation and experimentation, is certain to be costly; and, although arrangements of inter-agency pooling of resources could produce economies of scale and limit individual agency losses, there are safer investments to make. Moving beyond continuing education will impose its own costs, including examination construction and administration, audit arrangements, and greater administrative expenses incurred as a result of more complex interactions with applicants for certification of continuing competence. Many certifying agencies already rely to a tremendous extent on volunteers in the profession who are willing to proctor examinations, administer and "score" oral or proficiency examinations, serve on examination committees, or participate in the construction and continued evaluation of certification programs; to approach the same reservoir of volunteers with additional requests for participation in continuing competence programs, which in some cases may be resented by peers, would be an unwelcome assignment for certifying agencies.

Perhaps, the best that could be said in response to all these disadvantages is that any effective program of continuing competence assurance is bound to be expensive, difficult to implement, particularly challenging to members of the profession who are asked to participate in administration of the program, and uncertain in result. Even this catalog of obstacles, however, is no excuse for inaction. Continuing competence is too important to health care, and too great an opportunity for professions currently under fire for failing to police themselves adequately or to place the public interest before professional interests, to be answered faintly.

Directions for Implementation

Any systematic method for assuring continuing competence would have to be implemented in stages, merely because of the magnitude of the undertaking. In this case, the Commission itself, which already has a membership criterion for certifying agencies that they adopt a plan for assuring continuing competence, could be expected to develop guidelines for assessing whether a particular agency meets this generally worded criterion. The "choice" method would comprise a low common denominator for certifying agencies in that each agency could choose among the range of methods and would not be rejected solely on the basis of its choice of method. The Commission also could be expected to serve a useful function as a forum for discussing ideas in continuing competence and for promoting or conducting research into implementation of the various methods.

This proposal champions choice, but is fair to assume that any standards for continuing competence assurance programs, whether the standards are developed in the Commission or by another group, will not permit infinite choices. For example, a certifying agency that chose to maintain only a program of voluntary continuing education presumably would not meet any meaningful standards of continuing competence assurance. On the other level of choice, individuals presumably should not be free to meet continuing competence requirements by submitting an individual program that was not evaluated by anyone or measured against any criteria or standards. To be credible, a program probably should be developing along all three dimensions of:

(1) External evaluation, by objective (written or proficiency) examination, practice audit, or portfolio review;
(2) Self-assessment tools; and
(3) Continuing education.

Indeed, these three dimensions comprise the framework of effectiveness of continuing competence assurance programs. It would be difficult to justify a certifying agency's decision to ignore any of the three in developing its own strategy of competence assurance.

Such a comprehensive program could be implemented by one certifying agency or by a certifying agency acting in tandem with a professional association or other organizations. Although such comprehensiveness presents a formidable, to some seemingly unconquerable, challenge, it is difficult to envision how a continuing competence program could be considered complete without including all three elements of: (a) offering or exploiting the availability of instruction to update skills and knowledge, (b) providing a means for individuals to identify their areas of relative weakness and strength, and (c) preserving the integrity of the credentialing mechanism by requiring a periodic and convincing demonstration of skills and knowledge related to competence.

How does such a voluntary effort relate to government regulation? One state, Michigan, has pioneered in the adoption of a continuing competence requirement for licensed professions. It is possible that other states will follow suit, or that the progressive Michigan effort will be thwarted or delayed into oblivion. In either event, waiting for the states to act is waiting too long and expecting too much of the licensure system. Professions and certifying agencies, demonstrating the capacity of the private sector to fulfill its public responsibilities, should act quickly and forcefully. In particular, they should face up to the work of making the types of decisions suggested above, or similar ones, and should be assembling appropriate expertise in an imaginative effort to design and tailor a program to the specifications and composite personality of a particular occupation and certifying agency.

The question of implementation raises the problem of whether certifying agencies should be attempting to construct programs for "recertification." This chapter has avoided use of this term, in an effort to divert attention away from the unappealing, possibly sterile issue of whether "recertification" means an extension of the entry-level certificate along the dimension of time with the content area functionally unchanged, or instead a refinement of the functional areas in order to be relevant to an individual's practice. Clearly, the current proposal is more in line with the latter view than the former. But, recertification is not the point: continuing competence is, and it is of no moment whether a particular program identifies itself or is identified as recertification or not, so long as it reaches or approaches the requirements enumerated in the early section of this chapter.

More positively, implementation suggests the need to identify appropriate directions for research. It is commonplace for policy reports to include a section at the end detailing "directions for research"; often this is done as an effort to please various research interests. In this case, the imperative for research is clear. Continuing competence assurance offers a solid way of improving on existing credentialing mechanisms and producing the higher quality of care and lower costs of care that inevitably should result from professional competence. The trick is to do so economically and with valid instruments. This surely does require greater study and research, including trial and error.

To a great extent, the availability of alternative routes for continuing competence assurance, coupled with the lack of evidence that any is inherently superior to any other, suggest the strategy suggested here. It is labeled the "choice" method precisely to emphasize the lack of rigidity and the need for effective, decentralized decision-making necessary in building a worthwhile system. Its success will depend on vigorous, determined, concerted effort; its failure would be assured by attempts to gloss over problems, or to develop feeble approaches that are almost meaningless. And, its success would be an achievement in which members of the health professions could have lasting pride.

Chapter 20

CONCLUSIONS

by

The Editors

This report presents a diversity of opinion about continuing competence assurance. And, opinion it largely is, because research efforts to date have yielded few generalizable findings on the efficacy or net advantages of particular approaches to the question of how to assess practitioners on a periodic basis in a way that promotes quality of care.

Although the opinions presented are diverse, they are in frequent agreement. This report does not provide a great clash of arguments. All authors tacitly agree that efforts at continuing competence assurance are needed and that no magic formula has yet been derived. Indeed, the authors appear to agree on more than that. This chapter presents conclusions that are indicated by the previous chapters.

Conclusion #1: Forces are pushing health occupational credentialing toward continuing competence assurance. It is increasingly recognized, as keynoter Raymond Salman expresses it, that "a credential earned when one begins a career may bear little direct relationship to the skills of the practitioner years later." Technologic advances - commonly reported by the press in the form of information about new medicines, innovative surgical techniques, and research discoveries - make it impossible to contend convincingly that an entry-level credential is a valid indicator of current knowledge. As noted by Peggy McCarberg and Robert Derbyshire, the half-life of contemporary medical knowledge is estimated at about five years.

Thus, as Glen Leymaster observes, consumers of health services are demanding evidence of continuing competence, but so too are a multiplicity of interests. State governments are moving to require demonstrations of continuing competence. Florida, Colorada, and New Jersey currently are re-examining continuing education requirements, while Michigan has moved beyond continuing education to allot the professions six years to take responsibility for continuing competence assurance. The state role as a catalyst for professional action incorporates the activity of state "sunset" commissions and proceeds from an awareness that, as noted by Salman, occupational regulation is no longer the exclusive domain of the regulated. The Michigan effort described by Eugenia Carpenter thus envisions statutory change as the product of the mandated examination of continuing competence assessment mechanisms. Besides state governments, the federal government, as suggested by Thomas Hatch, has come to believe that continuing competence assurance must be part of the credentialing process if the credentialing is to be rational and meaningful and do what it is supposed to do. Hospitals, concerned with escalating costs and with their own accountability, now realize that competence is a component of care, according to Bruce McFadden. Finally, Daniel Thomas notes the increase in health care expenditures nationally from 5.3 percent of the gross national product in 1960 to 9.1 percent in 1978, with over one-fourth of these expenditures devoted to professional services and most of an additional 40 percent involving hospital care being manpower costs, and he points out the concern of the insurance industry: "The extent of this concern," he states, "is reflected in the Health Insurance Association of America decision to work closely with the National Commission for Health Certifying Agencies as one method of addressing the problem of both entry and continuing competence of health care personnel." Competence, observes Thomas, goes to the questions of inappropriate procedures and utilization and unnecessary diagnostic testing, thus affecting both costs and quality of services.

Although medicine sometimes is credited with being the first profession to recognize the need for continuing competence assurance, Samuel Kalman demonstrates that the need for continuing competence was recognized by pharmacy as early as 1949 and that a 1972 House of Delegates resolution of the American Pharmaceutical Association mandated a study of possible approaches. The professions, of course, also have displayed some resistence to change that would require practitioners to submit to evaluations.

Nathan Hershey sees other counter-forces to continuing competence assurance on the horizon. Among them are labor unions, unlikely to accept recertification that could result in dismissal of senior employees, and antitrust authorities, such as the Federal Trade Commission, that may come to oppose credentialing programs of any kind that are not based on actual on-the-job performance.

Conclusion #2: The response to these forces thus far has been gradual and oriented to continuing education. Requirements of continuing education slowly permeated organized medicine, and Robert Derbyshire traces the landmarks: In 1947, the American Academy of General Practice established continuing education requirements for continued membership; in 1968, the Oregon Medical Association established such a standard for the first time for medical society membership; and in 1971, Derbyshire's own state of New Mexico established continuing education as a condition of licensure. Leymaster notes that now many medical societies and medical licensing boards enforce continuing education requirements. Editor McCarberg credits family medicine with being the pioneers of continuing education requirements, but she notes that similar state requirements are also faced by nurses, social workers, and others, but not, for example, by radiographers.

To Derbyshire, continuing education is the only way to keep knowledge current. He sees a need for continuing eduction even in the fact that 10 percent of physicians do not engage themselves in continuing education. Hatch states that continuing education requirements should be oriented to changes in the concepts and technology of the professions and should be aimed at a basic level of competence, as opposed to programs of advanced training and specialized skills beyond those required for basic competence in a profession.

Derbyshire describes the strength of resistance to continuing education requirements, alleging that the American Medical Association is among those forces in opposition to mandatory continuing medical education. Editors Neil Weisfeld and Dennis Falk sound a contrary note about the pace of acceptance of continuing education requirements, declaring that such requirements have been adopted relatively quickly if one considers the enormity of the shift in credentialing policy that such requirements signal. No author, however, is able to point to much of a pattern indicating that the professions are rapidly moving beyond continuing education and establishing requirements of continuing competence.

Conclusion #3: Continuing competence must be built on a foundation of initial competence. Likening initial and continuing competence to a double-edged sword, Salman asserts that initial competence can be assessed, although not easily, through testing mechanisms that can be put in place more readily than mechanisms of continuing competence assessment. Derbyshire indicates the breadth of the implications of competence, citing the definition in a 1978 report of the Committee on Continuing Competence of Physicians to the Coordinating Council on Medical Education that competence is an "array of attributes" that produces a "pattern of effective activity" directed toward the health of some population. Indicators of continuing competence enumerated by Kalman include: the level of mastery; proficiency in the application of skills; understanding of the practice and the task requirements; level of experience and motivation; and observable behavior. Somewhat in contrast to Hatch, Weisfeld and Falk contend that continuing competence programs should aim at improvement where there already exists competence, and they list eight requirements of acceptable continuing competence assurance programs, which appear to be generally applicable also to initial competence. All this suggests that continuing competence begins with initial competence, to which is added a measure of practical experience.

Continuing competence assurance programs are not seen in this report as an end in themselves, but rather as a frontier. Possible implications are suggested. Robert Burmeister describes one program certifying continuing competence that is expected to facilitate agreement in the licensing arena, where two national examination programs compete. He also suggests that certification may become a goal of academic programs. McFadden, too, foresees a working environment where credentials are mostly certificates instead of academic degrees. Thus, certification of continuing competence can help steer entry-level credentialing toward a competence base.

Conclusion #4: Continuing education requirements alone are not likely to satisfy society's needs with respect to continuing competence assurance mechanisms. Skepticism about the value of continuing education requirements clearly is growing. Carpenter documents such skepticism, citing a 1975 report by members of the Michigan Public Health Statute Revision Project to the effect that continuing education alone is insufficient to assure continuing competence, and she adds that continuing education provides the public with only a false sense of security. Salman similarly condemns the "enrollment criterion," stating that it does not work and has a placebo effect on the public. Explicitly agreeing with federal authorities, McFadden states baldly that continuing education does not assure competence.

Reasons why continuing education comprises only an incomplete program of continuing competence assurance include, suggests Salman, the need for an assurance mechanism to provide measurable outcomes. Hatch asserts that a standard is needed, and he maintains that standards should be criterion-referenced to the extent practicable. Derbyshire acknowledges arguments against continuing education, including the point that continuing education registrants may miss or not pay attention to instruction sessions. He and McCarberg summarize the mixed empirical evidence. The landmark Peterson study of general practitioners in North Carolina in the 1950s showed little influence of continuing education on practice, and a 1970 study of Kansas physicians similarly found no significant correlation between continuing education in pediatrics and obstetrics and perinatal mortality. More recent studies, though, suggest opposite conclusions, particularly when continuing education is tailored to specific practice objectives. A 1973 study report gave the Stanford "Back-to-Medical-School" Program favorable marks.

The authors suggest various ways in which programs to assure continuing competence can move beyond continuing education. Medical specialty boards, relates Leymaster, are combining continuing education, practice evaluation, and examinations for re-certification. Four boards are making such programs mandatory, and guidelines of the American Board of Medical Specialties suggest an interval of six to ten years between examinations. He also notes that nine state medical boards accept recertification with an examination in lieu of continuing education as a qualification for relicensure. Ayers D'Costa discusses how continuing education can be tied to self-assessment, as Diana Mass demonstrates in the case of the Competence Assurance System of the American Society for Medical Technology. These developments suggest that continuing education is a *sine qua non* of continuing competence assurance, but not the *ne plus ultra*.

Conclusion #5: No method of continuing competence assurance has emerged as the best approach for use by all credentialing programs. Further work with a variety of methods is indicated. Weisfeld and Falk see no clear direction in the development of policies for assuring continuing competence, but they list, and other authors describe more fully, the methods of voluntary and mandatory continuing education, self-assessment, re-administration of entry-level examinations, administration of mid-career examinations, peer and audit review, proficiency examinations, practice simulations, and individual portfolios. Like those editors, Kalman favors multiple means of assuring continuing competence and contends that the professions should assume greater responsibility for the competence of their members. As a multiple approach, Weisfeld and Falk propose a combination of continuing education, self-assessment, and external evaluation. Leymaster urges that programs be geared to the practice area of practitioners and that they evaluate practitioner ability. Salman agrees and states strongly that, no matter which approach is taken to assure continuing competence, inaction on the part of the professions is not a viable alternative.

With regard to evaluation, Salman declares that testing has emerged as a real possibility for assessing continuing competence. Geraldine Ellis sees a potential for audit as a form of evaluation and observes the commitment to audit of the Joint Commission on Accreditation of Hospitals as well as the Health Care Financing Administration. But Kalman notes that tests, like continuing education, have serious shortcomings in the capacity to predict, and he stresses the alternative of self-assessment.

As Kalman observes, self-assessment centers on the individual. D'Costa describes the self-assessment project of the American Academy of Physician Assistants that contained the steps of defining critical functions, applying the critical incident technique to identify practice scenarios, and administering a lengthy examination that allowed for extensive feedback. He does note problems with self-assessment, however, especially with regard to bias and reliability.

Reducing policy-making to the voluntary agency level, Weisfeld and Falk outline a proposed "Choice" method whereby a certifying agency makes decisions about the functional areas to be assessed, the methods of continuing competence assurance that are most appropriate to the profession, the showing that will be required of each candidate for recertification with regard to each such method, and ways to conduct on-going evaluation of the continuing competence program itself. A compatible proposal is Salman's "Sanctioning," which would restrict practice in line with competence without upsetting the existing licensure format. Authors of both proposals, along with editor McCarberg in a chapter on discipline, find it important that the maintaining of professional discipline is related to other programs of continuing competence assurance.

Conclusion #6: A delicate relationship exists between public and voluntary credentialing. This relationship could be upset by a failure to coordinate continuing competence assurance efforts between the two sectors. Certification, a voluntarily sought and obtained attestation of competence in practice, is fundamentally different from licensure, which is governmental approval to practice that confirms that an individual has the minimal competence necessary to protect public health. Leymaster clarifies the significance of this difference, asserting that certification should not be required as a condition of licensure. McFadden prefers the voluntary effort: "In whatever manner continuing competence may be measured," he states, "it seems extremely important that the initiative be of a voluntary nature." More interested in the public effort, Carpenter declares that licensing must be flexible, rarely lifting the right to practice on the part of individuals who use that right to earn a living, but she is firm in the belief that licensing must improve to meet the public demand for accountability. Between the two sectors, communication and cooperation are important for several reasons, including the securing of maximum benefits from limited resources and the need to prevent contradictory requirements in credentialing.

One area where greater cooperation is indicated, in the opinion of several authors, is professional discipline. Hatch suggests that discipline should be incorporated into certification programs. Salman says that disciplinary mechanisms must be reinforced. In the chapter on discipline, McCarberg notes that New York, California, and other states are in the process of shoring up their disciplinary programs, and she observes that voluntary associations and certifying agencies lag far behind licensing agencies in matters of discipline.

Conclusion #7: Development of an effective and efficient competence assurance programs requires extensive commitment in terms of time, financial resources, and volunteer effort on the part of leaders of the professions. Huge technical and cost problems are involved, as documented by Carpenter in her discussion of the experimental Michigan approach. Difficult undertakings she lists are defining and measuring minimally acceptable levels of competence, financing development and operations, determining the effect of the continuing competence program on the quality of services, making the program acceptable to professionals and feasible administratively, and determining the appropriate types of measures. Weisfeld and Falk discuss the requirements and barriers that should be met by continuing competence assurance programs, and they come out on the side of a pluralist approach that emphasizes self-assessment. Urging certifiers to face up to potential legal problems, Hershey states that continuing competence requirements can be no more difficult than initial certification requirements, so that re-administration of the entry-level examination may have to be an option in all cases. He also notes the legal importance of validity and reliability. McCarberg's chapter on discipline demonstrates that great effort also is required in constructing a viable disciplinary program.

Several authors recount the sequence of actions taken by particular associations or agencies in developing programs to assure continuing competence. Burmeister relates that the American College of Nursing Home Administrators, faced with a lack of previous work on role delineation, surveyed members of the profession to determine "important aspects of the job" and the importance, time requirements, and degree of involvement of an inventory of tasks. A program then was built that included a norm-referenced multiple-choice examination and a computer simulation of operations using teams of candidates with self- and peer-assessment ratings. To remedy identified deficiencies, individuals are required to submit a professional development plan.

The American Society for Medical Technology, in a program described by Mass, is working to define competence, provide opportunities to achieve competence, and monitor the relevance of the formal mechanism used to measure achievement of competence. Kalman relates that the American Pharmaceutical Association developed a list of 69 basic responsibilities of pharmacists. He notes difficulties in relating ability to practice, due to such elements as constraints in work situations. Outside of health, Edgar Fell discusses the extensive process used to examine periodically the competence of airline pilots through proficiency testing. This process includes observation, but it also incorporates education, experience requirements, a written examination, and the equivalent of clinical competence requirements in that a certain number of flight hours must be logged on the appropriate type of aircraft within specified time periods. Simulators as well as actual airplanes are used in the proficiency testing. Each of these programs suggests the enormity of the effort required to develop a program to assure continuing competence in a profession.

Conclusion #8: Cooperation among certification programs should produce important economies of scale, prevent duplicative effort, and generate momentum in creating credible continuing competence assurance mechanisms. The frontier of continuing competence assurance will not be charted by small bands of individuals striking out in opposite directions without communicating and cooperating with each other. Those working to develop such programs must learn from each other's experiences and must attain some coordination to develop and apply meaningful standards, prevent a proliferation of incompatible credentialing requirements, overcome resistance in the form of intransigence or apathy on the part of professionals, and avoid redundant or otherwise wasteful effort.

Specific opportunities for cooperation exist. Weisfeld and Falk note the importance of research, which can be coordinated among certifying agencies and professions to study the most important questions efficiently. McCarberg suggests possibilities in multidisciplinary programs that may serve as effective vehicles for continuing education, self-assessment, and evaluation. Hershey calls on the National Commission for Health Certifying Agencies to keep the eye of certification authorities "on the ball" and, in effect, to require due process in continuing competence assurance.

This last conclusion is in some ways the most promising one. It indicates opportunities for collective effort that could serve as a partial antidote for the growing fragmentation among health care providers. The conclusion implies that practical means exist to secure the great achievement of the development of valid, reliable, meaningful mechanisms to assure continuing competence. Implementation of this conclusion would move continuing competence from an era of occasional and generally uncoordinated effort to an era of combined, yet creative and diverse, activity. The need to create and implement programs to assure the continuing competence of health professionals is here. Its realization could serve as a model for complementary public and private-sector progress.

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